THE RELATIONSHIP BETWEEN HEALTH CARE COSTS AND AMERICA'S UNINSURED

HEARING

BEFORE THE

SUBCOMMITTEE ON
EMPLOYER-EMPLOYEE RELATIONS

OF THE

COMMITTEE ON EDUCATION AND
THE WORKFORCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTH CONGRESS

FIRST SESSION

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Friday, June 11, 1999

House of Representatives

Subcommittee on Employer-Employee Relations

Committee on Education and the Workforce

Washington, D.C.

The Subcommittee met, pursuant to call, at 9:30 a.m., in Room 2175, Rayburn House Office Building, Hon. John A. Boehner, Chairman of the Subcommittee, presiding.

Present: Representatives Boehner, Petri, Ballenger, Fletcher, Andrews, Kildee, McCarthy, Tierney, Wu, and Holt.

Staff Present: Mark Rodgers, Workforce Policy Coordinator; Robert Borden, Professional Staff Member; Christopher Bowlin, Professional Staff Member; David Connolly, Jr., Professional Staff Member; Rob Green, Professional Staff Member; Amy Cloud, Staff Assistant; Deborah Samantar, Office Manager; Gail Weiss, Minority Staff Director; Cassie Lentchner, Minority Labor Coordinator; Woody Anglade, Minority Labor Associate; Cedric Hendricks, Minority Deputy Counsel; Marjan Ghafourpour, Minority Staff Assistant/Labor.

Chairman Boehner. Good morning, everyone. The quorum being present, the Subcommittee will come to order.

We want to welcome all of you this morning, especially our witnesses. We appreciate all of you making the effort to be here today to help us understand exactly what is happening in the health insurance marketplace as it relates to costs and coverage.

Under rule 12 B of the Committee rules, any oral opening statements are limited to the Chairman or Ranking Minority Member. If other Members have statements they wish to have submitted, they will be included in the Hearing record without objection. All Members' statements will be inserted into the record.

OPENING STATEMENT OF CHAIRMAN JOHN BOEHNER, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

This Hearing is part of our continuing effort to provide proper context for this Subcommittee as we prepare to undertake one of the most important domestic issues of our day, the vital topic of health care reform. I think all of us are in agreement on the need to proceed with reforms that will guarantee additional protections for patients and ensure accountability in what has come to be known as managed care.

But most Americans would agree that genuine health care reform isn't just about managed care and making it more accountable to patients. Equally important are the concerns of the 43 million Americans who lack health coverage all together. Our continuing challenge is to find ways to expand protection for managed care patients while expanding access to care for the 43 million uninsured.

Our previous Hearings have explored this question from many angles. We have looked at ERISA and how it works. We have looked at claim review procedures and proposals for review of denied claims. We have looked closely at the market-based reforms known as association health plans which many believe have the potential to reduce costs and make quality health care more accessible for those who don't have coverage.

But before we undertake any comprehensive reform of our nation's health insurance system, we must closely consider the impact our actions will have on those who have no health insurance. To put it simply, we must understand why the uninsured are uninsured, and that is part of the purpose of today's Hearing. Rising costs were a key issue during the 1980s when Americans suffered double digit premium increases that put quality health care out of the reach of many, but by the mid-1990s, it was widely believed that the cost problem had been defeated. With the advent of managed care premium stabilization costs in many cases grew at a rate lower than inflation. Now I believe that we have turned yet another corner with studies showing premiums on the rise once again.

Through the years, Congressional action on health care has closely tracked these trends. When premiums were rising in the 1980s and early 1990s, the number of uninsured Americans was approaching 40 million. We had a great debate about cost containment and universal coverage. After 1994, when costs stabilized, many policy makers turned their attention away from the uninsured and focused more exclusively on the quality of health coverage the insured received.

With premiums now back on the rise and the number of uninsured at 43 million and climbing, we have no choice but to consider these problems in tandem. Patient protections on the one hand, costs and coverage on the other. Next week this

Subcommittee will consider legislative proposals that many of us believe will deal with both in a measured and balanced way.

I have said at previous Hearings that we must be aware of the trade-offs that occur when we place additional regulations on employer sponsored health plans. More regulations mean higher costs, and higher costs means reduced coverage. We may differ on the degree of that relationship, but I think we can all agree and acknowledge that it does in fact exist. As we begin the legislative process of managing those trade-offs, I thought it would be particularly appropriate for our witnesses to describe to us the atmosphere in which we will be making these decisions.

I should emphasize that these witnesses have not been asked to solve all of our policy challenges in their testimony. They will tell us what is happening out there on the issue of costs and coverage and why it is happening. I would ask all of our Members, if they could focus on those questions as well.

WRITTEN OPENING STATEMENT OF CHAIRMAN JOHN BOEHNER, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE – SEE APPENDIX A

Again, thanks to the witnesses for being here and all of you, and I would yield to my colleague from New Jersey, Mr. Andrews.

OPENING STATEMENT OF RANKING MEMBER ROBERT ANDREWS, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

Mr. Andrews. Thank you. Good morning. I am very much looking forward to hearing what the witnesses have to tell us this morning. As Chairman Boehner just said, there are some important factual and empirical questions which deserve a thorough hearing, and I am confident that those questions will receive such a hearing this morning.

I am also pleased that this Subcommittee of all the Committees in the House is taking the lead in finally legislating on the issue of the rights of patients and changes in our health care system. Beginning next week, we will commence a process designed to debate and consider all the various options that are available within the jurisdiction of this Committee. It is timely. It is something that Members on our side are looking forward to, and I trust that this morning's testimony will empower us to make even better decisions about the issues in front of us.

With respect to the growing number of Americans without health insurance, it is very important to understand relationships that exist between changes in the costs of private health insurance or employer purchased health insurance and the degree of

coverage. It is also important for us to keep in mind issues that may be outside the jurisdiction of this committee but are awfully relevant to the question of getting more people insured.

In addition to looking at the relationship of the cost of private insurance and the number of uninsured persons, Congress should also consider President Clinton's proposal to make Medicare available to more people through a buy-in program or other kinds of mechanisms. Congress should re-examine the efforts to insure more children. I believe that the action that we took in the 1997 Balanced Budget Agreement on a broad bipartisan basis has had a positive effect throughout the country. We need to look to build upon the success of that 1997 legislation to insure more children.

We need to look at some of the proposals that have been made by Members of other Committees, proposals such as that of Congresswoman Johnson from Connecticut that would attempt to insure more individuals by the use of the Internal Revenue Code as a source of public subsidy for the purchase of private insurance.

I think it is important that we not only emphasize the risk of people losing their coverage because of increasing prices, I think it is important that we look at the opportunity of expanding coverage for people by other legislative tools that this Congress has at its disposal, the Tax Code, the Medicaid program, the Medicare program and changes in the insurance marketplace which might make more insurance available to more people at a lower price.

I am confident that today's Hearing is a part of that effort. So I am pleased to be a part of the Hearing. I would also say that we do need some rigorous analysis of the often stated truism that when the price of something goes up there is less of it. How much does the price have to go up to create less of it? How much will prices, in fact, go up? How much price sensitivity is there among those who are already insured? How much price sensitivity is there among those who are not? These are some of the issues that I am sure we will deal with this morning.

I look forward to this morning's testimony. I especially look forward to our efforts which will commence next week to begin to consider changes in the law, and I yield back the balance of my time.

Chairman Boehner. I thank my colleague and friend from New Jersey and all of the Members for making the extraordinary effort of being here this morning, given that the House does not have votes and given that we were here until midnight last night casting votes on the legislative branch appropriations bill.

Today, we have decided to alter our Subcommittee policy and will have two panels of testimony. On the first panel, I am pleased to welcome Dr. Dan Crippen who is the Director of the Congressional Budget Office. Joining him this morning is Dr. William Scanlon from the General Accounting Office where he serves as Director of Health Financing and Public Health Issues. Gentlemen at the table understand we have a 5-minute rule. Your written testimony will be made part of the record. You can proceed Dr. Crippen.

STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, D.C.

Mr. Crippen. Thank you, Mr. Chairman. From the charge that you outlined in your Opening Statement, as well as the Opening Statement of Mr. Andrews, we say something that is probably obvious but important: What has happened is easier to describe than the why, and not knowing the why makes it even more difficult to prescribe solutions.

Let me say that we should remember our recent past. Despite several factors that might boost health insurance coverage such as the growth of the economy, expansions in Medicaid eligibility, state insurance reforms, federal legislation to improve the portability of health insurance, initiatives to expand insurance for children and several years of slow growth in health insurance premiums, the percentage of Americans who lack health insurance has nonetheless grown. Despite our best efforts, the number of people without insurance is likely to continue to increase.

Health insurance premiums will grow more rapidly than in the recent past, and more low-income families will move off the welfare rolls and Medicaid into entry-level jobs that do not offer coverage. Policies that further increase health care costs and premiums could result in larger reductions in insurance coverage than might otherwise occur.

What I will attempt to do today, Mr. Chairman, is outline what we know about the characteristics of the uninsured population and describe recent trends in health care costs and insurance coverage. According to the Current Population Survey, about 43 million people under age 65 lacked coverage as of 1997. That estimate represents 18.3 percent of the non-elderly population and compares with 14.8 percent who lacked coverage a decade ago. Most uninsured people were in working families, and one-quarter of them were children. More than half of them were in families with income below 200 percent of the poverty level. Low-wage workers and those in small firms are much more likely to lack coverage than other workers. The percentage of the population that is uninsured varies widely from state to state, depending on the characteristics of the workforce and state regulation and law.

Competition among health plans, Mr. Chairman, in the recent past and the associated shift from indemnity to managed care plans have contributed to a dramatic slowdown in the growth of health insurance premiums in the 1990s. On average, the annual rate of increase in premiums fell from double digits in the late 1980s and early 1990s to
2 percent or less in 1995, 1996, and 1997. Over the past year, however, premiums have begun to grow more rapidly again. Some analysts and health plans are predicting increases in the range of 6 percent to 10 percent for this year and next. Others are predicting even larger hikes.

Data from the Current Population Survey indicate that coverage of non-elderly adults fell steadily until 1992, remained relatively stable until 1997, and then began declining again. The percentage of non-elderly adults who were uninsured rose from 15.6 percent to 19.7 percent. Coverage of children increased slightly from 1987 to 1992

and then started to fall. By 1997, 15 percent of children remained uninsured.

Analysis based on those data suggests that the reductions in the coverage rates that occurred between 1987 and 1992, a period in which premiums were growing rapidly, were attributable primarily to lower rates of employer-sponsored insurance. One cannot, however, infer causality solely on the basis of that apparent association. Subsequent declines appear to be attributable mainly to falling rates of Medicaid coverage, with the proportion of the population with employer-sponsored insurance remaining relatively steady through 1997.

Another recent study which was based on data from other surveys taken in 1987 and 1996 found that the proportion of workers with employment-based coverage from any source fell from 76 percent to 73 percent over that period. Studies suggest that the decline generally resulted from lower rates of participation in employer-sponsored plans rather than reductions in the rate at which employers offered coverage.

Health care costs are rising for many reasons, including changes in medical practices, the development of costly new technologies, and greater use of prescription drugs and other services. Government regulation at both the state and federal levels can increase the cost of health insurance and lead to higher premiums. States also regulate the premiums that insurers charge for health policies, often by requiring premiums charged to small firms to fall within specified categories or limits. Consequently, the good risks tend to drop their coverage which raises the average cost of insurance for those who remain in the group.

Employers who offer health coverage would react to the additional cost imposed by health insurance mandates. Employers might respond, as you have heard from other witnesses, to rising health insurance costs by reducing the generosity of insurance coverage, perhaps by raising cost-sharing requirements on beneficiaries or by eliminating benefits. Some employers might drop health coverage altogether. They might also reduce the generosity of other employee benefits or reduce the size of wage increases; as economics tells us, employees tend to pay most of those costs.

Employees and others buying insurance in the individual market would also respond to rising health insurance costs. In general, higher premiums are likely to result in some loss of coverage, although the magnitude of the drop is uncertain.

The number of people without health insurance continues to grow despite the booming economy and expansions in Medicaid eligibility. Rising health care costs have made insurance increasingly unaffordable for many Americans. Proposals that would impose new mandates on health plans and insurers are meant to improve the value of insurance to customers, but they could also increase insurance costs and exacerbate the problem of the uninsured.

Other proposals are intended to increase health insurance coverage by creating a less regulated environment in the small-group market through such vehicles as association plans and health marts. Although those proposals could encourage the entry of some lower-cost health plans, they might also decrease coverage among the higher-risk groups.

Mr. Chairman, despite good economics and good policy intentions, the number of uninsured has continued to grow. It is not altogether clear why. What is clear, however, is that further raising the cost of insurance won't help. Thank you.

WRITTEN STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, D.C. – SEE APPENDIX B

Chairman Boehner. Mr. Scanlon.

STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C.

Mr. Scanlon. Thank you very much, Mr. Chairman and Members of the Committee. I am very pleased to be here today as you discuss the impact of higher health care costs on the problem of the uninsured.

You asked me to present the findings of a study that we did for Senator Jeffords, Chairman of the Senate's Health, Education, Labor and Pension Committee, last July that analyzed the relationship between private insurance premium increases and changes in the numbers of insured. Specifically, I will focus briefly on the trends in the employer's decisions to offer insurance and employee's decision to purchase it and an assessment of the recent studies that have estimated the relationship between premium increases and insurance coverage.

As you have heard from Dr. Crippen, recent studies have shown that employers typically do not stop offering health insurance coverage when premiums increase. Between 1996 and 1998 health insurance premiums, unadjusted for inflation, increased by almost 8 percent per year on average. But despite these increases the fraction of small firms with fewer than 200 employees offering insurance coverage, grew from 46 to 49 percent. At the same time, 99 percent of larger firms were offering insurance. As a result, the fraction of workers that were being offered insurance by their employers grew slightly. However, fewer workers chose to accept that employer-based coverage for themselves or their dependents leaving a smaller portion of the work force covered by employer-based insurance as Dr. Crippen indicated to you.

The fall in the acceptance rate may be partly attributable to what employees were required to pay for insurance in the form of their share of premiums. While the employee's share of single coverage premiums averaged between 12 and 13 percent in 1998, it rose to 33 percent in small firms and 22 percent in larger firms by 1996. Senator

Jefford's particular interest was in how much insurance coverage might change because of an increase in premiums due to Federal mandates imposed on health plans. There are relatively few studies that have analyzed the relationship between an increase in the cost of insurance and a change in number of individuals covered. However, two studies by the Lewin Group did attempt to answer this question.

In November 1997, the Lewin Group estimated that 400,000 fewer people might be covered by health insurance if new legislation caused premiums to increase by one percentage point. A second study released in January of 1998 indicated a lower, potential coverage loss of 300,000 individuals for every 1 percent increase in premium.

In our view, these estimates may not be precise or accurate predictions of potential coverage loss. Limitations in the data, methods and assumptions utilized to make the estimate all contribute to our concern. At the heart of the concern is the fact that the information on the premiums employees paid for insurance was not available and had to be imputed. Since how individuals respond to premium changes is the key issue, having only an estimate of premiums employees face and not the actual amount introduces uncertainty into the results.

Our second principle concerned the simplicity of the assumptions made regarding how mandates would influence premiums and premium changes would affect coverage. It was assumed that mandates would uniformly affect premiums of all types of coverage, whereas in reality they would affect different types of coverage to varying degrees, managed care plans the most and indemnity life insurance the next. Individuals may then see a premium for the coverage increase, but rather than foregoing insurance they may opt for another type of coverage with a smaller increase.

Similarly, it was assumed that plan offerings would remain constant except for the mandated changes and the associated premium increases. What has been happening over the past decade or more is that plan offerings have been curtailed or restricted to keep premium increases down and to maximize sales or coverage. Similar changes could occur with the mandates.

Consumers may find that the catastrophic protection insurance offers is still attractive, even if some of the first dollar coverage they had or the flexibility in benefits or providers that they had are sacrificed.

I would like to conclude by making an observation that extends beyond this issue of health care costs and insurance coverage because the work we did for Senator Jeffords was very similar to work we had done for Chairman Bliley of the Commerce Committee in 1996. That work involved an analysis of what would happen if the number of Medicaid enrollees, I am sorry, of what would happen to the number of Medicaid enrollees if the program were converted to a block grant. The conclusion of that work was identical.

Although forecasts have been made with the best data available and built upon a set of reasonable assumptions, forecasts involve inherent uncertainty. At a minimum, forecasts are better discussed as a range. Everyone here is familiar with poll results that will report that 52 percent of people say something with a margin of error, plus or minus 3 percentage points. It also needs to be recognized that forecasts made with the best available data based on a set of reasonable assumptions may result in an estimated range

that does not coincide at all with the estimated range based on equally good data and alternative reasonable assumptions.

Forecasting the impact of potential policy changes has become and absolutely should be part of the policy deliberation process. Recognition though of the uncertainty in forecasts also should be part of that process and factored into decisions whether to adopt the policy and in building in safeguards to a policy to accommodate undesirable consequences if forecasts prove erroneous.

Thank you very much, Mr. Chairman. I will be happy to answer any questions you or Members of the Committee may have.

WRITTEN STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C. - SEE APPENDIX C

Chairman Boehner. I thank both of our witnesses this morning for coming and sharing their testimony with us. As I read the testimony that you have submitted, it appears clear that to some extent you both would agree that rising costs have some negative impact on access to affordable health insurance. Is that correct?

Mr. Scanlon. Yes.

Mr. Crippen. Yes.

Chairman Boehner. I am going to ask both of you. Of the various legislative proposals you have analyzed can you identify those general types of proposals that would be most costly in terms of additional costs compliance?

Mr. Crippen. Mr. Chairman, we don't have a lot of research evidence on that. One characteristic I could suggest, perhaps, is that some of these proposals would tend to weaken managed care systems, that is to say, blow up the networks or weaken the ability to manage the care. In the stronger form systems, the more it would weaken the systems the more likely it is to cause systemic cost increases. As you threaten what managed care has accomplished, for good or for ill, you also threaten the cost savings that they have been able to engender in the recent past. As a general statement, I think that is about all we know. There are some proposals that have more threat, if you will, to those networks and systems than others.

If, for example, the remedy for a patient recipient was that the judge was able to grant a remedy that would be system-wide, network-wide or managed care plan-wide, clearly that would have more impact than if the remedy was just granted to that individual patient.

Chairman Boehner. You are referring there to a judgment or a decision that would widen the definition of medical necessity?

Mr. Crippen. Well, it could be any of those things, yes. Under ERISA, as you know much better than I, traditionally the remedy is to grant the benefit the applicant was desirous of. In the case of health care, particularly under networks, what the remedy would be is a little less clear. If it was simply the procedure in this case that the patient was desirous of and it didn't affect the plan, that is one result as opposed to a judge perhaps giving a remedy that would affect the whole plan.

Chairman Boehner. Mr. Scanlon.

Mr. Scanlon. Mr. Chairman, I think that in our work we have been struck by both the dynamics of the situation as well as some of the apparent contradictions that seem to emerge. One of the things that we found in looking at managed care organizations is that over time many of the practices that we are talking about in terms of mandate are being increasingly adopted by different managed care organizations, in part because of the fact that interest has focused on these issues and that from a market perspective perhaps it becomes attractive to tell and reassure consumers that you are offering them sort of a better insurance policy.

At the same time, sort of what we are dealing with is a lack of solid evidence but a lot of sort of information or some subjective assessment of what might happen that is inconsistent with some other information. I will give you an example is the issue of sort of appeals. On one level there are concerns about how much appeals would add to the cost of policies and the contradictory information is that there are very few denials reported by plans.

So it doesn't seem to be sort of all in balance. Sorting this out and sorting it out in a dynamic environment has been a very difficult task.

Chairman Boehner. Mr. Scanlon in your testimony if I recall correctly, over the last 10 years or so you have seen an increase in the number of employers offering plans to their employees, yet a decreasing number of employees taking advantage of those offerings by the employer. If I recall your testimony correctly, you have indicated that this possibly could be a result of the employee having to pick up a higher percentage of those premiums. Can you spend a little time talking about what has happened to the employee share of premiums?

Mr. Scanlon. Certainly Mr.Chairman. Immediately prior to 1990 employee's share of premiums averaged about 13 percent in small firms and about 12 percent in larger firms. By 1996, they had increased to a level of about 33 percent in the smaller firms and 22 percent in the larger firms. These are very sizeable increases, especially when you combine them with the fact that the level of premiums were increasing on average about 8 percent a year during that period. So what employees were facing in the form of higher health care costs or health care premiums were very, very real. We would anticipate that some of the response in terms of declining coverage is a result of those higher premiums.

Those premiums would have been even higher if we hadn't seen the kinds of changes that have occurred over this period in terms of insurance offerings. We are talking today about managed care in part because managed care has become very

prevalent in the insurance marketplace. In a response to increasing costs managed care has been seen as a means to deal with that, and therefore it has become a much more predominant portion or part of the insurance offerings that workers face.

Chairman Boehner. Of the number of employees who are offered insurance by their employer, how many of these employees across the country actually participate in the plans?

Mr. Scanlon. In 1996 it was about 80 percent, which was down from about 88 percent at the turn of the decade and disproportionate by age groups. Younger people, perhaps with a feeling of invincibility, are more likely to turn down coverage whereas older people are much more likely to accept coverage.

Chairman Boehner. Mr. Andrews.

Mr. Andrews. Thank you, Mr. Boehner. I would like to thank both gentlemen for their testimony and begin with Mr. Crippen.

You make the statement, as I said in the beginning, that it is a truism that when you raise the price of something it becomes less frequently purchased. That seems to be the case, but you also set forth what kinds of price increases make a difference, to whom and under what circumstances. I accept that.

You are aware of the fact that ERISA does not cover millions of covered lives. About 30 million covered lives or more of people, for instance, who work for local governments who work for other kinds of plans not covered by the ERISA pre-emption. Are you aware of any research which indicates that premium increases in those plans have behaved differently than premium increase patterns in ERISA plans?

Mr. Crippen. I am not aware of any. That doesn't mean it doesn't exist.

Mr. Andrews. I am aware that you haven't been asked to answer that question prior to this morning, but I would ask you and your staff to go back and take a look at that, that we do have a laboratory of sorts here. We have millions of Americans who are provided health insurance by their employers who are not subject to the rules of ERISA, and it would be very instructive to find out whether the patterns of premium increases or decreases have tracked ERISA plans or not. I think that would be an interesting thing for the Committee to find out.

SUBMITTED FOR THE RECORD, RESPONSE OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC, TO QUESTION OF ROBERT ANDREWS, RANKING MEMBER, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE - SEE APPENDIX D

Mr. Andrews. Mr. Scanlon, I want to ask you a question that I don't necessarily subscribe to this position, but it is kind of striking. If someone was brand new to this debate and hadn't thought about it at all, they would find the following data in your

testimony and might ask the following question: Between 1995 and 1997 you say that real health insurance premiums remained constant or fell slightly across all plan types. Did the number of uninsured people go up or down between 1995 and 1997?

Mr. Scanlon. It went up.

Mr. Andrews. And prior to 1995, in the 5 years prior to 1995, there was inflation adjusted growth as high as 11.6 percent for indemnity plans and 10.6 percent for HMOs. Did the number of people, uninsured people go down or up during that period?

Mr. Scanlon. It went up.

Mr. Andrews. Did it go up faster in the period prior to 1995, or did it go up slower or did it go up the same?

Mr. Scanlon. I am afraid I am not aware of the difference.

Mr. Andrews. Well, we know something about this. At the beginning of the decade, we used to toss around the number of 40 million uninsured. Now it is 43 or 44, but it would seem to indicate that the rate of growth in uninsured people has been about the same during that seven or 8 year period, hasn't it?

Mr. Scanlon. I think it hasn't changed dramatically, but I wasn't sure whether it changed in one direction or another in those two periods.

Mr. Andrews. Although I don't subscribe to this position, I would like you to consider it. That would appear to support the conclusion that there isn't much of a relationship between the number of uninsured people and price increases at all, that there is a certain steady growth in the rate of uninsured people, at least the number of uninsured people, that occurs in times of high premium increase and low premium increase. What is wrong with that argument?

Mr. Scanlon. Well Mr. Andrews, I think that it is an issue of are there two factors or is there one factor. The price increase and the outcome you are interested in in terms of who is covered and that there are many other factors are influencing whether or not someone is covered. Decisions to offer insurance by employers appear to be often made or most predominantly made for the longer term. They are going to get into this. They are going to continue it. It is not going to be something that they want to take away from their employees when prices rise. So new employers that we have do in terms of an expanding economy is they may not immediately jump into offering insurance to their employees.

We have also heard over this time period about increases in the number of part-time workers and numbers of contract workers. Part of this is a way for an employer to control costs because very often benefits are not offered to such workers.

Mr. Andrews. To come back to something that I asked Mr. Crippen about, it is correct, isn't it, that there are millions of people who are employees and their families who are not subject to ERISA pre-emptions, who therefore are in plans that are subject to state mandates and subject to torte liability for decisions by the plans? Are you aware of any evidence that there are greater rates of premium increases in those plans than in plans

covered by ERISA?

Mr. Scanlon. We did some work probably about 5 years ago looking at some of the state mandates and not just the incremental change to premiums. We identified that there were increases in premiums due to the state mandates, though it was a lot smaller than what many people had speculated. How much those contribute to increases over time we haven't measured. Probably one of the difficulties we have here, and I think you have indicated quite rightly that we in some respects have a natural laboratory in terms of people that are covered by ERISA. Unfortunately, we have very little data on the experience of people that are covered by state mandates in any of these different circumstances to be able to make comparisons and to draw judgments.

Mr. Andrews. We have little data, but we do have the commonsense experience that we don't hear complaints from State and local officials about insurance premiums that are any different than the complaints we hear from the private sector. I mean, there isn't any out-swelling of support that says there is a crisis in that sector than doesn't exist somewhere else. Have we heard that?

Mr. Scanlon. Probably the primary factor behind health insurance premium increases has been the changes in medical care and in technology which have forced premiums across the board to increase. I think that the incremental changes that are associated with any one thing are often overwhelmed by that grand change.

Mr. Andrews. Thank you very much.

Mr. Crippen. Mr. Andrews if I could just say, bear with me for 30 seconds, that in terms of economics looking at the premium changes alone doesn't tell you much. You can't reach a conclusion on one side or the other in whatever argument you are constructing.

What is important is the total cost of health care and how that finds its way through to employees as part of this picture if they have more co-pays, deductibles, less coverage, or lower wages in the future. Many of those things can happen that aren't reflected or captured by just the premium number alone. So I think no matter which side of the debate you are taking about, looking only at premiums won't give you much comfort.

Mr. Andrews. I appreciate that.

Chairman Boehner. The gentleman from North Carolina, Mr. Ballenger, who is tieless.

Mr. Ballenger. Thank you, Mr. Chairman. Some of us are relaxed. I am going home. Y'all can stick around if you want to.

I would just like to add that I am a manufacturer who has a plant that is not ERISA, and I read your statistics on the percentage of real annual growth in premiums. I must say you got 1991 to 1998, and in some of them you actually show a decrease. I can truthfully say I have never seen a decrease in premiums. They go up every year, and I think it has to do with the age of your employees. If you happen to have a firm that has

been in existence for some length of time, your age group goes up and so your sickness goes up and so your premiums go up.

I think everything you said that applies to ERISA applies to non-ERISA things. I can remember in 1950 our company paid everything. We take you and cover you and your family and everybody else and it was cheap. But then it came along and we only paid for the employee and this is 5 or 6 years later. Ten years later we went to co-pay. Then we went to we pay 80 percent of the cost "up to" and the employee picked up the difference. Then we limited the amount of money that would be paid in certain cases, and finally we went to self-insurance, and to PPO.

I can truthfully say that our insurance premiums, although we did increase the number of employees, back in the 1950s when we started cost the company about $5,000 a year; I should have it per employee but I don't. It is now costing us about $750 thousand dollars a year. The one thing that scares almost every manufacturer who pays insurance, especially those that self-insure, is that somewhere down the road somebody is going to invent a law up here that makes us liable although we are giving substantial amounts of money.

So it makes us liable for what is going on here, and having obviously only examined ERISA that means you would not have looked at states that have allowed liability to occur. Are there any studies at all that have shown once liability comes to employers, the number of employers that decide to forget it and say we will give you the money and you insure yourself? That is one thing that I hear over and over again from small employers that, you know, if it really gets down to the nitty-gritty and you make us liable because we are self-insuring there is no reason we should carry on.

Mr. Crippen. I am not aware of any specific that looks at states that have adopted liability exposure or increased exposure for it, but the national aggregates don't suggest that happening quite the way you talked about it. That is to say, as both Mr. Scanlon and I said, the number of employers offering some form of health insurance has been relatively constant; actually increased a little in the recent past. So employers aren't abandoning coverage in any systematic way that we can see. There may be a state out there that is not part of that pattern, but I am not aware of it.

Mr. Scanlon. We tried to review that area about a year ago and did not find any work of that type then in part because I think the state entering into this field is relatively limited; Texas being the primary state.

Mr. Ballenger. How often do you find or have you even found at all, states that do allow liability and suits that do occur?

Mr. Scanlon. Well, it is an issue I think of allowing liability in some respects. Not being an attorney I would be very careful here, because it is an issue of whether a state can do something that does approach ERISA plans in terms of liability. What has mostly been an issue is the plan itself, or the issue of what constitutes a benefit determination versus what constitutes medical care. The court cases that have been tried seem to fall into two groups; those where plans are held liable because of the fact that they were involved in delivery of medical care itself, and then cases where they were not held liable because it was considered a benefit decision and therefore pre-empted by ERISA.

Now the employer's role in that, as a non-lawyer, does not seem to be apparent to me. I am not sure whether we will also see this as an area of dynamics. The legal theories are changing, and so where we will see this go and what the employer's role might be is something that is uncertain at this point.

Mr. Ballenger. Well, considering the growth in population and the growth in number of jobs over the last eight or ten years, it would appear to me comparatively speaking that the uninsured population went from 40 million to 43 million. The insured population should have gone up substantially also. Do you have that statistic?

Mr. Scanlon. I don't have the number but the percentage of people that are uninsured has risen slightly.

Mr. Ballenger. Just slightly?

Mr. Scanlon. Well, right.

Mr. Crippen. Depends on which group. The non-elderly adults have grown a couple of points.

Mr. Ballenger. Is there any statistic anywhere that shows, I know it has always been effective back home that when you offer the insurance where they pay for the family or a certain amount of it if the employee happens to be around 19 or 20 where you are going to live forever, they would rather have the money in their pocket? Are there substantial numbers of people that are offered insurance but decide they just don't want to put that little bit of money away?

Mr. Scanlon. Actually, there are for people under 25. The percentage that accepted the insurance that was offered to them dropped 70 percent from 85 percent, whereas among the overall population it is still at 80 percent. This means that older people are much more likely to accept coverage.

Mr. Ballenger. I am just curious. If we pass some federal law, could we pass a law that would mandate that everybody has to accept insurance whether you want it or not? I mean, you know, these youthful kids, they would rather have a beer.

Chairman Boehner. Well, I would note for the gentleman from North Carolina that there is some experience with that as states have mandated auto insurance coverage and the rates of coverage continue to decline. So I am not sure that mandating the purchase of insurance has worked very well in that history.

The gentleman from Michigan, Mr. Kildee.

Mr. Kildee. Thank you, Mr. Chairman. Next Wednesday the Patients Bill of Rights, H.R. 358, will be, to use our terms, ripe for a discharge petition, and I am sure there will be a number of people lining up to sign that discharge petition. Aside from the independence of the judiciary which you mentioned, Mr. Crippen, what other major factors make it so difficult to arrive at a cost estimate of the Patient Bill of Rights?

Mr. Crippen. It is hard. There are a fair number of unknowns about how everyone out there is going to react. We have seen providers, for example, react to other federal

legislation in ways we didn't anticipate. So a lot of what we face is the uncertainty of how the legal community, patients, providers and plans will react. What we have done is look at a lot of possibilities, some of which would frighten you, if you will, about the potential costs increase. We put very low probabilities on many of them. So in essence, we have to make some guesses or informed judgments if you will, about the likelihood of any of these cost avenues manifesting themselves. When it is all said and done one of them may or may not occur, but we have put low probabilities on many of them happening and it really is the uncertainty of what is going to happen.

We, for example, asked a number of ERISA attorneys from the outside to help us think about how the Patients Bill of Rights might work under ERISA. Of course, most of them are used to a different set of issues. In fact, it took us about an hour just to establish a vocabulary because what I think of as a plan, they think of as something very different, and so it took us a while to begin to communicate. We have undergone those kinds of efforts to try and understand how the law would work under ERISA as you have proposed it and in turn how people would react to it. There is just a lot of uncertainty, I have to be frank, about how people will react.

My guess is no matter what number you put on an estimate, it is either going to be lower or higher and probably substantially lower or higher than the number you put down. Either the networks will be broken up and the cost savings we have seen in the past will disappear or they won't. There will always be some administrative costs.

So, again, it is a matter of informed judgment of what the reactions of the many players are going to be.

Mr. Kildee. I have been in Congress for 23 years, and the CBO plays a very important role and the most part usually you come up with a more precise figure, and this is probably in my memory probably the vaguest estimate that I can recall. Mainly, again, it seems to come back you mentioned just not sure how a judge may apply a particular case, whether it is, you know, specific or general.

Mr. Crippen. For example, as I alluded to with the Chairman a few minutes ago, if the remedy granted went to the compensation system or the membership of the plan, how many doctors were in or out, those kinds of things, that has a much more profound effect than if a particular procedure was granted to a patient as a remedy. It is those kinds of things we don't know what the judges ultimately are going to do, and we are not sure even from some of the drafting of the legislation how much leeway they would have.

Mr. Kildee. There is no model out there in this country or any other country that you could study?

Mr. Crippen. Not that we found. I am sure we looked for benchmarks wherever we could find them. I do want to say that what our professionals have done is look at each aspect of the bill and try and figure out how it would be implemented; how many people it would take to do the reviews inside and outside, literally how many people. Then work that from a very micro sense up to a macro estimate. So there is a lot of thinking and logic behind it but at the end of the day it is still imprecise.

Mr. Kildee. Do you have any comment on that, Mr. Scanlon?

Mr. Scanlon. Yes, Mr. Kildee. I agree with Dr. Crippen in terms of the difficulty of this task. I mean, I think there are no models in the rest of the world because the American health care system is unique in terms of its heterogeneity. I also think we underestimate, sort of, how much heterogeneity exists under all the labels that we apply.

When we talk about managed care, it ranges from the preferred provider organization to the staff model HMO, and that is changing constantly. We find that if you look at managed care organizations on the west coast that they differ from managed care organizations on the east coast. The question would be if we do anything in terms of changing the requirements for these plans, how are they going to react and how is that going to influence the cost level. At this point in time, that is all sort of an unknown. We don't have the experience from the past to be able to build a good estimate. We always feel very fortunate that it is CBO's job to do estimates and GAO's job to go in and look afterwards and see what the consequences of things were. So we appreciate the sharing of this responsibility.

Mr. Kildee. Well, I really appreciate your uncertain but very candid answer. Some people like to speak with great authority and put a figure on it, but I do appreciate your response. Thank you very much.

Chairman Boehner. Mr. Petri.

Mr. Petri. Thank you very much, Mr. Chairman. I want to start first by commending you for the initiatives you have taken in having this series of Hearings and moving forward with this important legislation. In this area I am struck by the injunction I guess we normally attribute to doctors that the first thing to do is do no harm. We are confronted with a very dynamic, rapidly changing health care system here in the United States. We all know that.

I can't drive through a community in my part of the world where there isn't a new health clinic going up, a hospital wing closing, new types of nursing care, graduated facilities being offered, and enormous changes going on in the health care system. I do think we have to be a little bit careful that with good intentions there is a desire to avoid potential abuse as we go forward. We don't want to end up sort of screwing things up for a lot of people, first of all with good intentions but not understanding it. In that connection, I wonder if you could help us understand some of these statistics a little better.

I am struck by the fact that you said there is a very low rate of uncovered people relatively in the Midwest and in New England as compared with California, probably Texas and Florida and some of those areas of Nebraska. In Wisconsin, we think we have the lowest rate of uninsured people in the country, even though Hawaii has a state mandate that they have to have insurance. We have traditionally had more people covered without a mandate.

Does this have to do with undocumented residents, things like that, as much as it does with some other dynamics? I mean, we may not be really focusing on the problem. The problem is that undocumented people aren't getting insurance coverage or temporary workers aren't getting insurance coverage as opposed to stable people who want coverage

and aren't getting it somehow.

In a tight layer market, employers want to provide it. Employees want it. Employers want the coverage to be fair and good in almost every instance because they want to have happy employees, and if they aren't happy they are going to find another job. So there is at least some discipline in this system.

Can we provide better discipline or should we be a little cautious or are there models? Let me just say, a lot of mandates or efforts at mandates do occur and different provisions occur from plan to plan and state to state. I don't know if it is the role to ask you this or not? Can you sense some mandates or provisions that are growing either as options or as definite parts of a plan that seem to be working in terms of not raising the cost too much but making people feel better about it? I am sure people in a competitive marketplace are looking for things like that.

Mr. Crippen. Let me start at the end and go forward. We have not done, and I don't know anyone who has done quite what you suggested to see after implementation at the state level the relative costs of different mandates. As to your larger question, immigration certainly can play a role in the patterns we see state by state. It doesn't have to be undocumented or documented.

Immigrants tend to start after they get here in the relatively lower paying jobs, and those are the kinds of jobs you would expect don't offer insurance coverage or indeed the employees that take it even if it is offered. So if California is a place where immigrants tend to get started in the country, then you wouldn't be surprised that that would have some effect but not necessarily in a sense of documented or undocumented.

The other factors involved are the degrees of unionization, for example. You wouldn't be surprised that the higher degree of unionization tends to have higher coverage. So the work pattern and work force patterns are important as well. The state regulations and mandates as you said, all play into this variation we see across the states which is much more dramatic than I expected.

Mr. Scanlon. Some of the variation that we see in insurance coverage across states is directly related to the Medicaid programs. The very significant differences that exist in both the programs are in terms of who is eligible for coverage as well as how well states have reached out in terms of trying to make people aware that they are eligible and get them actually enrolled. We have, over time, reported on the fact that there are several millions of children that were eligible but were never enrolled. Now with the children's insurance programs, there are much more aggressive efforts to try and get some of those children coverage.

Wisconsin is an example of a state that felt with the children's insurance program they had already been doing a good job. Here they had additional moneys but they were going to have more trouble using them than potentially other states because of a good job they had done historically. That is, I think, a factor that has influenced this variation across different states.

Chairman Boehner. Thank you, Mr. Petri. Mrs. McCarthy.

Mrs. McCarthy. Thank you. I am sitting here just thinking right before I came to Congress, I became a single woman, and I had to pay for my own health care insurance which came out to about $250 a month. When I came to Congress and they offered me health care insurance, it was wonderful. It was great. It was a perk, I guess.

We have so many Federal employees, you know, so obviously we are very large pool. So I am always confused when we have such large pools out there of whether it is large companies and everything else on why their premiums are so much higher than ours. I mean, they are, they are almost tripled I would tend to think, but the thing that I want to talk about is that I talked to an awful lot of young couples.

When I say young couples, they are probably like 30 to 35. They usually have two children, and I consider them making a decent salary. Between the two of them they are probably making 70 to $100,000 a year, and yet they will say to me they don't have health care insurance, and I will say why. Even when going back when I was a young married woman with my husband; and we had our first child, we thought health care insurance was fairly expensive, but we still went for it.

Is the attitude for a lot of people, all right, if I get sick, someone is going to take care of me anyhow, and is that driving up our costs? Because obviously if someone in the government or the State is going to pick up that health care because everyone is going to get health care eventually, one way or the other. If you go in a hospital and you have no health care insurance, you are going to be taken care of. I mean we all know that.

So is that driving up the costs of health care also? I do understand health care has gone up. Technology today is absolutely wonderful. People that we can save today we couldn't save 10 years ago. So that is expensive. Part of your life as far as taking care of someone has gone up.

So with all that we are trying to do and we want to make sure that everybody has basic health care. A majority of people really don't go to the doctors until it is way too late. That is one of the big problems, preventive care, which health care, HMOs, were supposed to do have not lived up to that, and I think if you talk to the Majority Members, by the time we get to a doctor it is like why didn't you see me a month ago. You know, we all tend to do that, and I would think we are a perfect example of the American people. So people wait too long, but I am just curious on if there had been any studies as far as people that should be able to buy health care insurance or at least go into with their employer are not still not doing it.

Mr. Scanlon. I am not aware of studies that have looked at it from the perspective of attitude. I know that we have seen the impact of higher costs in the fact that younger people tend to decline coverage at much higher rates. I think the premise that you always will get coverage is something we should educate more people about. Certainly the coverage for the uninsured has been documented very well as not the same necessarily in terms of the extent of treatment and the quality of treatment that someone with insurance can get. So I think there is a need to have insurance and it is of significant value.

Mrs. McCarthy. I agree with you. I was in nursing for 32 years, and thank God I talked my son into getting health care insurance. Thank you.

Dr. Fletcher. [Presiding.] Thank you. I appreciate the Chairman providing this Hearing and your testimony.

You know, as I look at and have spoken to my constituents and really look at even what most of the general public feels, the number one concern I hear by and large is the cost of health insurance and the rising costs, the ability to afford it and the decisions that families make every day. Are we going to continue to provide health insurance, or are we going to have to stop that so that we can put food on the table, and provide education for children? I remember hearing from a young lady back in 1996 when we were looking at some health care reform in the state, and she spoke of this issue because we did some health care reform that raised the costs and made it less affordable. I think if we don't see a correlation between costs and the uninsured we can't see the forest for the trees.

Everyone that does anything in the market understands if you raise the cost of the product it is going to decrease the number of folks that purchase it. So number one concern is cost. Number two, I think is access to care, making sure that physician and patients decide the care, not insurance companies, not judges, not attorneys. Rather physicians and patients decide the care. There is a great deal of interest in making sure that people can choose their provider, that they want someone that they trust.

You mentioned and I know several states that have increased their mandates and done health care reform, my home state being one example. Our number of uninsured increased from 400,000 to about 507,000. I take for granted some of that could have been Medicaid, but not all of it.

That is a 25 percent increase in uninsured. We did some health care reform that was well intended but very, very misguided. I am just concerned here that we don't have a politically motivated debate with discharge petitions and other things that don't allow us to honestly debate this issue of what is best to address the public concerns and to make sure that the right folks make the decisions, that we don't increase the costs, and that we continue to provide the care and not only that but work to decrease the number of uninsureds and make it more affordable and more available, not less, by some political tools that may try to drive a wedge and really deflect us from what the real concern and interest should be.

Let me ask you, if you increase the price who are the most likely to drop their health insurance? What group of individuals? Mr. Crippen. And Mr. Scanlon, if you could both address that.

Mr. Crippen. We know presumably, more of the same. That is to say we know that lower-wage workers tend to be the most likely to be uninsured. So it would be the lower end of the income scale presumably.

Dr. Fletcher. You agree with that, Mr. Scanlon.

Mr. Scanlon. Very completely.

Dr. Fletcher. What about the young and healthy. Would that be a group that drops it?

Mr. Crippen. As Mr. Scanlon has already said, presumably yes, some at least don't take that now. I mean while it may be an attitude problem as well, it is really an economic rational.

Dr. Fletcher. It is a cost benefit analysis. I am healthy.

Mr. Crippen. And my outlook is, I am not going to need anything for the next 10 years.

Dr. Fletcher. One of the points that you make is individuals that are dropping insurance are those individuals that put money into the system and take relatively small amounts out of the system because they are the low utilizers.

So what we have got if we increase costs? Who we are going to hurt? We are going to hurt the poor and the young families. I think that is what we have seen in our state, and that is why I am very concerned. We can have some very noble ideas in making sure that we do the right things. Yet we increase the cost and decrease insurance on the poor individuals and the low-income families that are in those low-income jobs because they are not able to take insurance because they can't afford the cost sharing aspect of it. We drop out those individuals that put money into the system; the low utilizers that help share the cost. So that is a major concern I have had.

When we talk about increase in liability, let me ask you, in the plans that you have seen come out does it include Medicaid and Medicare? Are they liable in the same way that some of these other plans want to make private plans liable? Have you done any analysis on the cost of that?

Mr. Crippen. No, I think the legislation we have been asked to analyze does not include Medicare and Medicaid.

Dr. Fletcher. How many people are in Medicaid and Medicare?

Mr. Crippen. Medicare has 39 million.

Mr. Scanlon. Thirty-nine million and an additional, approximately 30 plus million in Medicaid.

Dr. Fletcher. So we are talking about 70 to 80 million people that are covered. We have got a great deal of concern expressed by many that we want to make sure that they have this option, and yet they don't have that in Medicaid and Medicare. Is that right?

Mr. Scanlon. No, but they have other protections. Medicare in some respects has already got some of the protections that are in some of the legislation that we have had. They have an appeals process for example.

Dr. Fletcher. An external review process and those sorts of things to make sure that the decisions that are made are appropriate?

Mr. Scanlon. That is right. The other thing that Medicare beneficiaries have today is the ability to opt out of managed care completely. They have more choice in that regard than do many employed individuals in that they can always return to the traditional program

and use services.

Dr. Fletcher. Do you think if there were more options that that would be helpful also for employees?

Mr. Scanlon. For employees options are one of our strong views about the reform of Medicare in that we would benefit greatly from quality-based competition among health plans. The same thing is true in the private sector: If employees have choices and plans can compete on the basis of information and quality, we would probably have a much better health system.

Dr. Fletcher. Thank you very much. My time is up. Mr. Tierney.

Mr. Tierney. Thank you, Mr. Chairman. Thank you both for your testimony here today. Let me try not to cover ground already covered and just sort of synopsize here. What I am gathering from you is that if you are trying to project the effective price changes on a plan, you are able to use estimates but you can't get to firm numbers; is that right?

Mr. Scanlon. That is correct.

Mr. Tierney. That is basically because all your estimates are based on assumptions that you were forced to draw?

Mr. Scanlon. Correct.

Mr. Tierney. The assumptions all change. They can vary.

Mr. Scanlon. There can be more than one set of reasonable assumptions.

Mr. Tierney. As you change each one then whatever conclusion you might draw changes. So what we are dealing here are estimates and your best speculation is a guess as to what the result might be.

Mr. Scanlon. Correct.

Mr. Tierney. Let me just ask you also if we were somehow able to arrest the decreasing real value in wages and we are able to give more purchasing power to the individual employees, would we then suspect that more of them might opt to take the coverage that their employers would provide them?

Mr. Scanlon. I would think it would. I mean economics would suggest that health insurance is a good thing and that as incomes rise you would want to consume more of this good thing.

Mr. Tierney. So if we were to raise the minimum wage, for instance, more people in that category might be able to then opt into being covered in some form?

Mr. Scanlon. Not exactly sure what the impact would be because many persons that are going to be affected by minimum wage change would also be eligible for Medicaid.

Mr. Tierney. I have no other questions. Thank you.

Dr. Fletcher. Mr. Holt do you have any questions?

Mr. Holt. No questions at this time, Mr. Chairman.

Dr. Fletcher. I think that probably concludes this unless anyone has any comments. Let me just ask one more thing as we close this out and that is we mentioned Medicare and Medicaid, that they don't have this option that some of the bills have recommended. Why do you think that is that Medicare and Medicaid don't offer the option of some liability?

Mr. Crippen. If you are speaking strictly about liability, you mean federal probably because they are federally-provided programs.

Dr. Fletcher. Do the Medigap HMO's, fall within that category also? Help me out with that.

Mr. Crippen. No, Medigap is strictly private insurance, although it is predicated on a set of regulations. We have set up 10 types of policies that you can buy under Medigap, and the content coverage of those policies are pretty well prescribed by law or regulation. So Medigap is private in that sense. But Medicare and Medicaid are obviously public, federal dollars mostly on-budget.

So I don't know exactly how to answer your question. Some of the provisions that are in the Patient's Bill of Rights, as Mr. Scanlon said already apply to Medicare. And indeed most Medicare recipients, something like 85 percent, are still in traditional fee-for-service not in managed care.

Dr. Fletcher. Let me just make a comment on that. I have dealt with Medicare. It is far from fee-for-service now in the way it is implemented. There is a lot of 'I can't draw a CBC on a patient without putting specific diagnosis and going through things.'

It is far from the old indemnity fee-for-service plans, so let me make that clarification. I haven't seen one of those plans in years. But in any case, it seems that there is a concern of cost? Is that the reason that those may not be liable? The Medigap HMO's I am talking about.

Mr. Scanlon. I would like to try and get you some information because while the proposed legislation doesn't include Medicare and Medicaid, there is an issue of whether or not HMO's that contract with the two programs would have any liability.

Dr. Fletcher. We appreciate that information.

Mr. Scanlon. In the past the assumption has been based on ERISA, and these are not ERISA plans when they are contacting with Medicare or Medicaid. So we will get you some information to clarify this and provide it to your staff.

Dr. Fletcher. Thank you very much.

And if there is no further questions I think we will move to the next panel and thank you all very much.

Chairman Boehner. [Presiding.] It is my pleasure to introduce the second panel of distinguished witnesses. Our first witness on the second panel is Mr. Michael Anderson who is the Manager of Total Health at the 3M Corporation, St. Paul, Minnesota. The second witness will be Tracy Cassidy who is a principal at William M. Mercer, Incorporated. Our third witness will be Dr. Deborah Chollet, who is the Vice President of The Alpha Center, followed by Mr. Charles Kahn, President of the Health Insurance Association of America. And finally Sal Risalvato.

Mr. Risalvato. Close.

Chairman Boehner. Risalvato, excuse me, who owns the Riverdale Texaco in Riverdale, New Jersey. And I think all of the witnesses know that your entire written statement will be included in the record. And I ask that you stay as close as possible to the 5-minute rule.

Mr. Anderson, you may begin.

STATEMENT OF MIKE A. ANDERSON, 3M MANAGER OF TOTAL HEALTH, TOTAL COMPENSATION RESOURCE CENTER, ST. PAUL, MN, ON BEHALF OF THE BUSINESS ROUNDTABLE

Mr. Anderson. Good morning, Mr. Chairman, Congressman Andrews, and other Members of the Subcommittee. My name is Mike Anderson, and I am the Manager of Total Health of 3M Company. I am here today on behalf of the Business Roundtable. The Business Roundtable is an association of Chief Executive Officers of leading U.S. corporations representing 10 million Americans whose health care benefits cover approximately 25 million Americans.

I appreciate the opportunity to appear before this Subcommittee to share our health care experiences. I have also submitted written testimony on behalf of the Business Roundtable. 3M employs over 73,000 worldwide with over 38,000 in the United States. We are one of the largest private employers in the State of Minnesota where our headquarters is located. Our health care coverage provides coverage for 140,000 lives in the United States.

I will address four fundamental themes today. First, I will talk about the basics of our plan in order to illustrate how 3Mers have flexibility and choice of doctors, and access to appropriate treatment of their choosing. Second, I will talk about our overall strategic approach to health care that ties to our corporate values. Third, I will discuss how our benefits and how our overall total compensation program looks at cost, quality, and overall value, recognizing we have limits within our total package. Finally, I will talk about the ERISA framework.

So I will start with a quick overview of our 3M health care plan which we offer to employees, retirees, and family members. We have representation in all 50 states with a heavy concentration in Minnesota with almost half of our employees, and the balance in a lot of other small, typically rural communities and medium and large communities. We offer multiple medical plans under one common design to 3Mers. This national plan design gives us the ability to offer comprehensive coverage with affordable premiums. For example, our $100 deductible plan which is our strongest plan option, is $24 a month premium for family coverage.

The plans are ERISA self-insured and are predominantly administered under a preferred provider or PPO organization. Our PPOs offer a broad selection of providers, and with our PPOs we offer direct access to any covered specialist without administrative approval, and we have other network provisions.

Why are health care benefits important to 3M? The foundation of our program really comes from our corporate values and our human resource principles. Our strategy focuses on the important relationship between health and productivity which is significant when you think about not only employees absent from work from illnesses but also impact of employees dealing with chronic conditions or family members that are ill.

Finally, it is important to note that our other human resource programs such as our employee assistance program plays an important role in people's complex health issues and are carefully integrated into our health care program. How do we measure results in what has been our experience? We use a variety of measures in our human resources area to look at, for instance, employee satisfaction where we have very high overall employee satisfaction with 3M as well as high satisfaction with our employee benefits program.

We also look at service quality health care. And finally, of course, look at cost and quality components again under this health and productivity umbrella. Our cost experience has paralleled the industry. In the late 1980s and early 1990s we had double digit inflation. However after a strategic plan was put together and implemented in 1994, the highlights of which are in the written testimony, our trend has been approximately 2 percent per year over the last 5 years.

However, our most recent national experience suggests a trend of 10 to 14 percent average. We recognize many other employers are experiencing premium increases up to 20 percent in some markets. Let me say a bit more about health care costs. Our ability to utilize ERISA allows us to focus most of our expenditures on health care delivery. Our administrative expenses are about 7 percent of overall expenses which are comparatively low. With these results, we have been able to put additional features in our plan like 100 percent coverage for preventive care.

Second, while our package is national in nature we do have significant differences in regional costs which you will see in the written testimony. This is an important issue because our employees are salaried and are paid on a national basis. Consequently, if they ever did quit or discontinue employees benefits, this could result in employees with significantly higher costs and they could depart the health care arena.

What do we expect to happen in the future? It appears health care inflation has arisen. We think the underlying issues of quality, consumer-related issues, cost shifting,

and aging population and consolidation all will contribute to this. It is our intention to stay in health care benefits. However, changes in legislation could result in diminished, reduced, or plan elimination.

The final area I will discuss is ERISA. I will also comment on other employers in Minnesota who are part of the Buyers Health Care Action Group. ERISA has provided the umbrella that allows us to be a national plan. The cost savings we have seen have allowed us to reduce our expenses and have comparatively better results than our comparable parts who are working in the insured market in Minnesota. We have passed these savings on in the form of lower premiums and higher wages. We believe we are in a unique position to engage our employees in this complex health related area. And, finally, the ERISA framework is a key important structure for us and the reappearance of costs in this make it imperative that we maintain that tool. Thank you.

Finally, in conclusion, I would say that 3M has actively managed our benefits through collaboration with our providers. Our strategic approach has allowed us to integrate a number of services.

Chairman Boehner. Thank you, Mr. Anderson.

WRITTEN STATEMENT OF MIKE A. ANDERSON, 3M MANAGER OF TOTAL HEALTH, TOTAL COMPENSATION RESOURCE CENTER, ST. PAUL, MN ON BEHALF OF THE BUSINESS ROUNDTABLE - SEE APPENDIX E

Chairman Boehner. Ms. Cassidy.

STATEMENT OF TRACY CASSIDY, PRINCIPAL, WILLIAM M. MERCER, INCORPORATED, WASHINGTON, D.C.

Ms. Cassidy. I would like to thank you, Chairman Boehner, and the Committee for the opportunity to appear this morning. For the past 12 years I have been with the firm William M. Mercer, Incorporated. I am a health care consultant, and I primarily work with large employers on the design and management of health care benefits provided to their employees.

Today I am going to address the topic by sharing data with you from the Mercer/Foster Higgins national survey of data on health cost trends. I am going to correlate that to data produced by the Employee Benefit Research Institute in an issues brief on Sources of Health Insurance and Characteristics of The Uninsured. It uses data from the current population survey.

First, taking a look at trends in employer-sponsored health plans, the data that I am going to work from, our survey data, is a survey that was established in 1986. In 1993, we began conducting the survey using a national stratified random sample which means that the results can be projected for all U.S. employers with 10 or more employees. We had over 4,000 respondents in 1998, and it is the largest most comprehensive survey on this topic. You have several graphs that I am going to speak from that will help you see the trends that I am going to talk about.

In 1998, our survey indicated the first major cost increase in 5 years. It was 6.1 percent. It is the highest rate of increase that we have seen since 1993. Health care costs have far out paced the medical components of the consumer price index which grew 3.4 percent in 1998 versus overall CPI in the U.S. of 1.6 for that same time period. Health care costs are projected to increase approximately 9 percent in 1999.

Migration out of traditional indemnity plans really slowed to a trickle in 1998 following years of sharp decreases. Enrollment in traditional plans eroded to only 2 percentage points in 1998 from 15 percent to 13 percent. Employee enrollment in the more restrictive forms of managed care which would be the HMO's and point of service plans fell slightly in 1998 from 50 percent of overall covered employees in 1997 to 46 percent. And this was quite a surprise for us when the survey data came in. Enrollment in PPO plans the preferred provider organizations, rose from 35 percent to 40 percent. And we think that this shift can be attributed to employee desire for more flexibility.

A big increase in prescription drug costs really helped fuel the overall cost increase. Employers reported an average increase in drug costs of 13.8 percent at their last renewal. There are some factors that have influenced the increase in prescription drug costs. I have listed them in the handout and they are the fact that drug prices have increased. We have new prescription drugs. There has been an increase in prescribing by physicians. Direct to consumer advertising obviously has a very big impact on the cost of prescription drugs as well as the implementation over the past several years of prescription drug card plans. And I would be happy to provide additional information on those factors or provide examples during the question and answer period if you are interested in that. There are other factors that have influenced trends. I mainly pointed to prescription drugs because they have had largest impact on cost increases.

As we shift to the topic of the uninsured, using the EBRI data, what we find is that the percentage of non-elderly insured Americans has been increasing since 1987. We had 14.8 percent uninsured in 1987 compared to 18.3 percent in 1997. However, it is important to note that the portion of Americans covered by employment-based health insurance has increased between 1993 and 1997 from 63.5 percent to 64.2 percent, a slight increase albeit, but it is an increase.

We correlated the data from the EBRI issue brief to the annual cost increase in employer-sponsored health insurance premiums. And that is the final grid in my packet of materials. And there are two important findings from this information. There is an increase in the uninsured from 1987 to 1990 which was an increase of from 14.6 percent to 17.8 percent at the same time that employers were experiencing double digit increases in annual health care costs.

In 1991, the annual rate of increase in cost dropped. It went from an increase of 17 percent to an increase of 13 percent as did the percentage of uninsured. You can see

the line correlation on the graph. The interesting thing, though, is as we look to a more recent period in time, the percentage of uninsured from 1996 to 1997 appears to be more closely aligned with the change in the percentage of Americans covered by Medicaid. From 1996 to 1997 the percentage of Americans with Medicaid decreased from 4.2 percent to 3.6 percent while the percentage of the uninsured population increased from 17.5 to 18.2 percent. For the same period, the change in percentage of workers with employment-based insurance really only shifted slightly. It was a change from 72.3 percent to 72.2 percent. So two different periods in time, two very different correlations to a change in the uninsured population.

While there does appear to be a link between the increase in employer health care costs, the increase in the uninsured population and the most recent one is more aligned with Medicaid. With that said, the cost increases that are projected for employer-sponsored benefits for 1999 as well as the year 2000 and beyond could have an impact on the future number of uninsured Americans.

Thank you very much. I appreciate the opportunity to speak to the Committee, and I would be pleased to address questions.

Chairman Boehner. Thank you very much.

WRITTEN STATEMENT OF TRACY CASSIDY, PRINCIPAL, WILLIAM M. MERCER, INCORPORATED, WASHINGTON, DC - SEE APPENDIX F

Chairman Boehner. Dr. Chollet.

STATEMENT OF DEBORAH J. CHOLLET, Ph.D, VICE PRESIDENT, ALPHA CENTER, WASHINGTON, D.C.

Ms. Chollet. Chairman Boehner, Members of the Committee, thank you for the opportunity to testify this morning about the relationship between health care costs and group insurance coverage of workers and dependents.

I would like to stress that my statement reflects my own views and not that of Alpha Center. I think you will hear from me much of what you have heard from the prior panel and from members of this panel, but I would like to opportunity to give a slightly different perspective on the issue especially from the viewpoint of low-wage workers in this country.

As you are aware, health care costs have continued to rise in the 1990s while inflation in the larger economy has been very low. As a result, health care continues to become even more expensive than other goods and services. Most importantly, it

continues also to be more expensive relative to the wages and family income of the minority of workers who earn very low wages.

Most of these workers qualify neither for public assistance nor for the same degree of tax assistance that we offer high-wage and high-income workers under the Federal and State tax codes. Families headed by a worker earning less than 20,000 per year in 1997 which is about a 150 percent of poverty for a family of 3 represent only 17 percent of families of worker families, but they are 54 percent of the uninsured.

The drivers of continued increases in health care costs are complex, and you certainly have heard already about prescription drug prices and the increases over the last several years. However, other factors are at play in the very high premium increases that employers have reported recently.

One important factor relates to the dynamics of the insurance industry itself. After years of aggressive low pricing, insurers seem to have reached the low point in an underwriting cycle. The cycle is defined as aggressive low pricing to gain market share, followed by rising prices as insurers attempt to restore profits. So just as we have seen generally stable or declining premiums over the past 5 to 8 years, the underwriting cycle suggests that we may see a similarly long period of rising insurance prices into the next decade.

Over much of the past 10 years we have observed declining rates of health insurance in coverage among workers, and you heard about that from all of the people who have spoken thus far. This pattern of decline in coverage has reversed during the last several years and rates of employer coverage have begun to rise as record high rates of employment have finally begun to drive some growth of the lowest wages.

Nevertheless, the upward trend of employer coverage that we have observed has not been sufficient, and the number of uninsured Americans continues to rise by about 1 million persons per year.

Most of the uninsured live in families of very low-wage workers. Several factors account for these changes. First, over the last two decades wages at the bottom of the scale have stagnated. As a result, the distribution of wages has widened and so has the distribution of income. Low-wage stagnation coupled with rising employee contributions for coverage in group plans appears to explain much of the fall in take-up rates that we have observed among low-wage workers since 1987 even when they are offered an employer plan.

Second, low-wage workers are four times more likely to be employed in small firms where health insurance premiums with the same benefits are much higher than are high-wage workers. In 1997, 21 percent of workers earning less than $20,000 a year, remember that is again that 150 percent of poverty approximately for a family of three, were in firms of fewer than 10 employees compared to only 5 percent of high-wage workers.

While low-wage workers are less likely to be insured in firms of any size, a low-wage worker in a small firm is about one-fourth as likely to have employer-sponsored coverage as a worker earning $40,000 or more in a large firm. About 28 percent of low-wage workers in small firms have employer coverage either directly or as a dependent

compared to 95 percent of high-wage workers in large firms.

During the last two decades the states have launched a number of experiments to increase employer coverage, especially in small firms. These experiments included low-cost insurance programs that were made low cost either via subsidized provider or by provider discounts which subsidized the plan, or they were bare-bones insurance plans that offered meager benefits.

More recently all states, some only in compliance with federal law, have enacted insurance reforms to make health insurance more accessible to high risk workers. Other efforts, including the formation of purchasing cooperatives have had no significant effect on insurance costs.

The lessons from the efforts are important. First, employers and perhaps also employees distrust experiments. They are reluctant to make an investment in buying a health insurance plan that may not be there in a year or two.

The second is that in order to make significant gains in coverage in small firms, significant subsides are required to reduce the costs to low-wage workers substantially. Small discounts are inadequate for these workers.

Finally, employers and workers want standard health benefits that offer good coverage for most health care services. Given standard benefits they presume standard quality because they have no real basis for discerning differences in quality.

Many states have begun to consider reforms targeted to these lessons. They include patient protection, but with respect to access for low-wage workers they also include permanent subsidized health insurance programs such as those in Minnesota and Washington and programs that help low-wage workers buy into employer coverage when it is offered such as those in Oregon and Illinois. Others are considering options for allowing parents to buy into the state's children health insurance program or ways to extend Medicaid eligibility to very low workers who are not now eligible.

However, as the states continue to struggle with the disparity between the cost of health care and the resources of low-wage workers, many analysts are reconsidering the federal tax treatment of employer-sponsored health benefits. The current code is inequitable by any standard, and it greatly favors high-wage and high-income workers over low-wage and low-income workers. All efforts to reduce health care costs are important such as revising the federal tax treatment of employer-sponsored benefits. For example, replacing the current exemption with refundable tax credits is likely to be the broadest and most successful avenue to resolving the growing problem with the uninsured.

I thank you again for the opportunity to address you this morning. And I would be pleased to answer questions or help you at any time.

WRITTEN STATEMENT OF DEBORAH J. CHOLLET, Ph.D, VICE PRESIDENT, ALPHA CENTER, WASHINGTON, DC - SEE APPENDIX G

Chairman Boehner. Thank you. Mr. Kahn.

STATEMENT OF CHARLES N. KAHN, III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, D.C.

Mr. Kahn. Thank you, Chairman Boehner. I am pleased to be here today to discuss the relationship between health care costs and America's uninsured.

Before I begin, I think it is important to note that health care costs and health insurance premiums are not one and the same. Health costs are a broad concept including all expenditures for goods and services related to health care, included but not limited to payments by insurers of third parties, out of pocket spending, and even government outlays.

Premiums on the other hand refer to the amount paid by private policy holders for health care coverage for certain personal health costs. Health costs obviously have a profound effect on premiums, but other factors also affect the level and growth in premiums over time such as costs of assuring solvency and the management of risk as well as changes in cost sharing and plan design. Today, I will refer to both trends in costs in premiums, but I wanted to make clear initially the differences between the two.

In response to the double digit inflation in the 1980s, employers became much more price sensitive purchasers of health coverage. Together insurers and employers made innovations and changes in coverage that benefit consumers by containing premium decreases, offering new health plan options, and enhancing coverage for preventative care and other services. As a result premium increases dropped dramatically to the low single digits in the late 1990s. This is reflected in chart handout number one which you have before you and is included in my testimony.

The growth of managed care and the resulting drop in premiums not only saved tens of billions of dollars but kept up to 5 million more Americans covered by their employers. Overall the employer-based system has been remarkably effective in covering American workers and their dependents.

The number of people covered by the employer-paid group health insurance has grown dramatically over the last 50 years. Nine out of ten firms with more than 50 employees offer health insurance. Even smaller firms one out of two offer health coverage to their workers. That amounts to 152 million Americans today covered by private employer-paid health insurance up from 145 million just a few years ago.

Despite the success in keeping costs of premium growth down, the number of Americans without health insurance, however, has continued to climb over this decade. Today, there are 44 million uninsured Americans. By the end of the next decade, there will be at least 53 million. And if the economy sours, that number could rise into the 60

millions.

The major reason that certain Americans are uninsured is because they simply cannot afford coverage. As you can see from chart two in your packets, the cost of coverage takes a much greater and growing bite out of the total compensation of poor Americans than it does out of those who are better off.

And the data reveals that 60 percent of the uninsured have incomes under 200 percent of the poverty line. The primary reason health insurance premiums rise is that health care is so expensive and that expenses continue to grow. Technological progress, breakthrough medical devices and prescription drugs, improvements in the medical procedures as well as the aging of the population all contribute to growth.

Currently, the coverage drivers of health care are drugs. Clearly drugs contribute to improving health of Americans. At the same time, the rapid increase in both the price and use of drugs could make drug coverage in particular and health insurance generally less affordable. If you look at chart number three in your handout, you will see that the drug growth now out paces the growth of hospital and physician spending and is projected to comprise over 9 percent of health expenses by 2000 which is double what it was in 1980. Moreover, hospital and physician expenses have continued to climb at the same time. While managed care can help moderate cost growth, there are cost drivers that will remain beyond the control of employers and health plans.

Further, so called patient protection legislation and other mandates also contribute to the cost of coverage. My chart number four illustrates that there has been a 25-fold increase in the number of state mandates since 1970. According to a recent study by Dr. Gail Jensen and Dr. Michael Morrisey, Ph.D., HIAA, nearly one out of every four uninsured Americans lacks coverage because of the price tag of state mandates.

These mandates have raised premiums by up to 13 percent for many businesses and the lion's share of the cost of these mandates has been born disproportionately by small employers. While most of the adverse legislation I cite has taken place at the state level, Congress has joined in recent years in promoting legislation that has detrimental effects on employers and the health care of consumers. Instead, we believe that helping to insure more Americans by making coverage more affordable should be job one for the Congress. So-called patient protection legislation would move in the opposite direction. It would drive up premiums and undermine the ability of many employers to offer coverage. Mr. Chairman, I thank you for the opportunity to share our views here today and am happy to answer any questions.

WRITTEN STATEMENT OF CHARLES N. KAHN, III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC - SEE APPENDIX H

Chairman Boehner. Mr. Risalvato.

STATEMENT OF SAL RISALVATO, OWNER, RIVERDALE TEXACO, RIVERDALE, NEW JERSEY

Mr. Risalvato. Thank you, Mr. Chairman, and Members of the Committee. I appreciate very much the opportunity to come here today and tell you my story.

I am in business today in the service station business 21 years, 2 months and 8 days. And in 1983, I decided it was a good idea to provide health care benefits for my employees. I did it for a number of reasons.

One, I am a concerned employer. Two, at the age of 24 I was what we could call today a health care deadbeat. I did not have any health insurance for myself. Three, in the service station industry it was not uncommon unless you were an auto mechanic in a dealership to have health care benefits.

So I knew what the pay scales were in other shops, I knew that my pay scale was competitive, but an added benefit would be to provide something for my employees that they weren't going to get somewhere else unless they went to work in a dealership. So I did this to compete. I need to compete for employees, and I need to compete for customers. And this was a way of competing for employees.

Now, we need to follow the history of how this whole health care crisis came about. A lot of employers did exactly what I did. It was far less expensive to provide these benefits than it was to provide pay increases. And big business during the 1980s started to let people go. I mean they increased their profits by eliminating workers. Small business was picking up those workers, and that is where the small business population has grown. that is why small business has hired most of the people that have grown this economy and have grown the work force.

So to compete with big business, I needed to do this as well. But most people were having these policies, these health care policies that literally kept them from even knowing what the cost of health care was. They had low deductibles, they went into the doctor, they paid these low deductibles. Once they met their deductible it did not matter what the final cost of health care was.

And large employers were not only providing the policies but were paying for the entire cost. We have seen that shift a little bit. It is one of the ways that I have maintained being able to provide health benefits. To this day, something I am very proud of is I have never taken a penny from an employee to pay for health care. I have always maintained the policy of paying 100 percent.

But the things that I have done to be able to maintain that have been heroic. I can't even remember the name of the insurance company that I had last year. I would need to go look in a ledger to see who I wrote the check out to under that column of health care because we are constantly changing. If we don't change them, they change their name.

We saw these increases, and they were huge increases. I spoke before this Committee on this same subject on April 30 of 1992; different name of the Committee and different Leadership. But I asked then for some marketplace reforms. I asked you to consider the burden that was being placed on small businesses and not only the burden, but I even tend to see this here today. It is almost a tendency to blame small businesses because small business have so much of the work force and the problem is that a larger percentage of small business do not provide health care benefits. But I need to make something very, very clear here today. The reason is cost, period.

Gentlemen, when you hear hoof beats you better look for horses. And we have a cost problem. If the cost wasn't so high, more small businesses would provide it. Let's get back to this big business, small business ratio. Proctor & Gamble just let 15,000 or say they will let 15,000 people go. Where are those 15,000 people going to work? Probably the same place that many of the other displaced big business workers have gone in the past 15 years, to small business.

They are either going to go to work for a small business that is expanding because that is how small business gains profits, they expand. So they will go to work for a small business in a large role, maybe in a role as a consultant. Or they may start their own enterprise. But in all of these instances, these 15,000 people not only don't have health care anymore but they don't have jobs either. If they go to small business they will at least have a job. And then there is going to be that struggle to get the health care. If the cost were lower, then there would be more likelihood that they would have the health care.

So what I am asking you is to please go back, keep your eye focused on the fact that the problem is cost, and that is a direct cost to small business. I am asking you to please take into consideration some of the things that I asked for in 1992.

One of them is the ridiculous tax policy that we have somehow maintained of not allowing a 100 percent deductibility of cost for a small business owner. Let me say this. I did not know when I took on health care benefits for my employees that I could not deduct my share. I am not sure that I would have gone through with it, certainly not in that year, maybe a year or two or three later, but it may have changed my mind.

Since I have been so involved in the issue there are many small employers that have discussed this with me and they say, do you know I can't deduct my portion? I started looking into it, and I am almost embarrassed to say, you are correct. Now, yes, we have changed that over the years. First of all Congress made me come back here every year begging to please continue the little deduction that we had. Now we have phased it in, and we are going to have the 100 percent thank you very much. But I certainly think it will be more helpful if we have that now rather than later and don't phase it in.

The other thing is to please give us some marketplace reforms. Allow us to group together to try and get some bigger purchasing power. Above all, please when you are considering these pieces of legislation, do not consider mandates. Mandates will keep the costs rising. And it is that rising cost that keeps small business from carrying and providing health care for its employees.

Thank you very much. I appreciate that you listened to my story, and I also will be very happy to answer any questions.

WRITTEN STATEMENT OF SAL RISALVATO, OWNER, RIVERDALE TEXACO, RIVERDALE, NJ ON BEHALF OF NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC - SEE APPENDIX I

Chairman Boehner. We will thank all the witnesses for taking their time to come in this morning and share your perspective with the Committee.

Mr. Risalvato, as cost increases to your business are occurring, how have you handled providing insurance to your employees? Are they paying the higher co-share? Do they have different policies? And what is the participation among your employees?

Mr. Risalvato. Okay. I would love to answer that question. The participation among my employees has always been 100 percent, and the reason for that is I have never taken a penny from them. So they have never had to chip in. It is really not a difficult decision for them.

How have I coped with these costs? Well, when I first started to realize that these were escalating, I was better able to afford them so it took awhile before I caught on and said, hey, wait we have got a problem developing here.

I then started to switch insurance companies. And every year I needed to have a new bid for the health care premium, and a new company would always come in and beat out everybody else. And then a year later when the premium came due again the policy came due, there would always be that exorbitant cost.

And I would always bring in the agent again, and we started to do that. One of the very innovative things that I did that leads me to ask you to please give small business some leeway because small business can't compete and self-insure the way big business can. I too sort of self-insured, and I saved a lot of money.

How I did that was I went to my employees and found out that none of them had in the previous year spent more than $15 dollars out of pocket. I had a $250 deductible. I raised the deductible on my policy, and, by the way, it was one of the years I stayed with the same insurance company because the rate went down so drastically. I raised the deductible from $250 to $500. And I told each of the employees that if this year, you present to me all of your out-of-pocket expenses when you reach $15 I will pay the difference between the 15 and the 25. And from there on, you are on your own as you would have been in the previous policy. I saved $6,000 in premiums. And I did not have to reimburse any of the employees one penny.

Now, that is an example of sort of self-insuring, although I don't have the ability financially or legally to get into any kind of a self-insurance situation. But if you address things like the health insurance pools, the AHP's you are more likely going to get small businesses into areas where maybe programs like that could be put in place. And a small

business could look and save some money and get into the providing of health care coverage.

Chairman Boehner. You mentioned the mandates and urged us to avoid mandates.You didn't have a chance, I don't think, to expound on them. You believe that mandates increase the cost of insurance.

Mr. Risalvato. We have a few different mandates that I would like to discuss. Yes, mandates have to increase the cost on insurance. If you require an insurance company to pay for certain items, in vitro fertilization, hair transplants, all kinds of reproductive procedures and things like that, you know what? I want my employees... I care about them... I want to make sure if any of them are ill, or need serious surgery that we can take care of that.

And that is far more important than seeing to it that the reproductive capabilities are taken care of. They are very, very expensive. It is just not the responsibility of myself as an employer, and certainly the rest of society should not have to take up these types of issues. Yes, let's take a little responsibility and help people to make sure that their basic needs are addressed. I believe we can do that. Mandates will not allow that.

Chairman Boehner. Mr. Anderson, you mentioned that your cost increases this year and you expect to be in the 10 to 14 percent range. Can you expound on why you expect these increases?

Mr. Anderson. Yes. We have, as we have been looking at our cost increases, begun to see that kind of pattern. Most of the industry has projected that, and we have seen that experience over a relatively short time period. Our experience has shown though that you have to look at costs over a longer time period. But the fact that we have seen it over the relatively short period and the rest of the industry is seeing it, leads us to believe that the trend is real.

Chairman Boehner. Have you seen any changes in the participation rates of your employees in your plan as you have had to increase costs? Although your participants don't pay much of a copay to join the plan as I recall.

Mr. Anderson. Right. No, we have not. I think we have a similar situation in that our plan is no longer free, but with the premiums that employees pay, and with the co-insurance, the cost sharing level is so low that we have not seen that. Also employees, unless they can show us they have other coverage, are basically required to have coverage. Our dependents are not. But, no, we have not seen that because of the nature of the way we have structured our plan to date. That is not to say in the future, if costs did increase, that that could change if we change our cost sharing structure.

Chairman Boehner. Mr. Anderson, how important are the health benefits you offer to your employees in the company? How important are those benefits to you as an employee? How important is that to you?

Mr. Anderson. This historically has been really important too, both in terms of the company and the employee. I mentioned we continuously monitor our employee satisfaction in a number of areas, and it has continued to be very high in the area of health

care.

The Corporation again places a very high emphasis on this for a number of reasons. Obviously, it is a competitive issue in terms of the offering. But also, I mentioned this health and productivity concept. We know even today we lose almost 1,000 employees a year out on illnesses at any given point in time. We are aware that that is really not the full value of the impact of health care and that we have a lot of people trying to deal with illnesses, et cetera. So it is very important. It is really a strategic piece of our total compensation package for us. And again our employees have always placed very high emphasis on it.

Chairman Boehner. Mr. Andrews.

Mr. Andrews. Thank you. I appreciate the testimony of each of the witnesses, and I especially want to welcome Mr. Risalvato back. I think I was here the day you were here in 1992 when the Committee had its correct name. And you have been a forceful and articulate advocate for our State particularly on small business issues. I have enjoyed our work together. I believe you were at the White House Conference on Small Business, right? That is how we first got to know each other.

Mr. Kahn, I wanted to ask you a couple of questions, examine the basis of your conclusions. You oppose the Patients Bill Of Rights because you assert it would drive up health care costs, increase the number of uninsured, and could destroy the fabric of the employment-based system. I wanted to examine the basis for those conclusions which I assume begins on page 1, the third paragraph of your statement where you say that as both the states and the federal government more aggressively pursue so-called patient protection legislation, and other mandates, there is mounting evidence that these reforms also have increased costs and have added significantly to the ranks of the uninsured.

I am going to assume that you are referring mostly to the states since we haven't enacted a Patients Bill Of Rights here in Washington at the federal level.

Mr. Kahn. In Health Insurance and Employee Accountability Act there were some amendments later that were mandates.

Mr. Andrews. You think they contributed significantly to this conclusion that you have made?

Mr. Kahn. I think all the factors in that legislation did, but particularly the state legislation has contributed to the factors.

Mr. Andrews. Let's look at the state legislation. On page 10 you examine the issue of litigation costs in defensive medicine. You give us, actually the top of page 11, you talk about the 1995 Stanford study which examined hospital outlays in states that have adopted reforms limiting liability awards. Did you look at premiums for those states or just hospital outlays?

Mr. Kahn. Well, as I said in my statement and as I say there, the primary driver of premiums are health care costs. So that all of these items that increase health care costs have an effect on premiums. And, in a sense, when I talked about the fabric of the system being undermined, the insurance industry is regulated and it will remain regulated

into the future. We can provide coverage for all the mandates. The question though is will small business and will other employers continue to provide coverage.

Mr. Andrews. But did the study look at other factors other than hospital outlays? The study that you cite makes the statement that hospital outlays in States with liability reforms limitations were, on the average, 5 to 9 percent less than States that did not have those reforms. Did you look at any factors other than hospital outlays?

Mr. Kahn. Well, that would affect hospital and physicians costs in states that have liability limits.

Mr. Andrews. Did you look at premiums? Did the study look at premiums in the 1995 Stanford study?

Mr. Kahn. It looked at costs and costs affect premiums.

Mr. Andrews. But did it compare premiums in the States that affected those changes and the states that did not?

Mr. Kahn. I would have to go back to the study.

Mr. Andrews. That is the only piece of evidence cited under the litigation cost section. On your benefit mandate section, you make reference to a Jensen-Morrisey study done on behalf of your association. We may already have this in our archives. If we do not, I would like to request a copy of study.

Mr. Kahn. Here is the study. I would be happy to have it put in the record.

Mr. Andrews. We may well have it. And the basis of your analysis here is that specific mandates on employers would have quantifiable increases on costs. Fifteen percent for mandated coverage for routine dental services. Does the Dingell Bill mandate routine dental services?

Mr. Kahn. No, I think the Dingell Bill does not.

Mr. Andrews. Thirteen percent for mandated coverage for psychiatric hospital stays. Does it mandate psychiatric hospital stays?

Mr. Kahn. I think it is highly probable in the legislative process that some kind of mental health parity provision could be added.

Mr. Andrews. Is it in the Bill now?

Mr. Kahn. No, it is not in the bill at the current time.

Mr. Andrews. Twelve percent for mandated coverage for visits to psychologists is that in the Dingell Bill?

Mr. Kahn. No, sir. That is not in the Dingell Bill, but the issues regarding medical necessity and liability have been scored by the Congressional Budget Office as adding costs. And there are a number of other issues that are now being considered by Congress

including changing the antitrust laws regarding physicians that would increase costs and my point is...

Mr. Andrews. Which are not in the Bill in front of us. The other study you make reference to is the Custer study which concludes that the probability of a person being uninsured goes up by 28.5 percent if certain mandates are imposed by states, small group community rating. Is that in the Dingell Bill? Is that imposed by the Dingell Bill?

Mr. Kahn. No, it is not.

Mr. Andrews. Guaranteed issue, is that in there?

Mr. Kahn. No that was an analysis of state laws and showed that states with certain types of regulation had higher costs than other states.

Mr. Andrews. I ask you these questions because it seems to me that the analyses and the conclusions on which you cite in your testimony don't bear upon the Bill that is in front of us.

You make a sweeping conclusion about the Bill, but then you don't really cite any evidence that talks about mandates that are in any relevance to the Bill. How can you draw the conclusion based upon these pieces of evidence?

Mr. Kahn. Let me answer that in two ways. One the Congressional Budge Office has shown that the provisions in the Bill would have an effect on the way insurance operates in all its forms and would increase costs to consumers.

Second, I will go back to my point about the Health Insurance Portability And Accountability Act. That Bill was signed into law in August of 1996. In September of 1996, that law was amended with two mandates, one regarding maternity and the other regarding mental health.

I won't get into the value judgment of whether those were good or bad mandates. My point is that once you go down the road of legislating this area first, the legislation you are considering will increase costs and, second, it provides an opportunity for amendment. And we have experienced both state level and with HIAA at seeing that mandates are clearly on the table and frequently added when you go into these kinds of reforms. That is my point.

Mr. Andrews. I do understand that. And I would yield back the balance of my time.

Chairman Boehner. Mr. Petri, do you have any questions?

Mr. Petri. Yes, just one or two.

First of all I understand, is it Dr. Chollet, that you are a Minority witness so I shouldn't be pleased with some of your testimony. I am because as one who has been troubled with the structure of the way we deliver health care, and understanding because of World War II and price controls of that time to attract and keep workers, employers started providing fringe benefits and that got outside of the controls. One of the principal benefits that employers at that time provided was health care. Before that doctors used to

make house calls, and it was a totally different industry than it has turned out to be today.

The system that we have today does leave a lot of people slipping through the cracks. It is also very regressive when you go through who gets the benefits and the quality care and so on. So, I have been one who has advocated for many years that we should try to figure out some way to either give small business 100 percent tax deductibility or give no one tax deductibility and use that revenue for a voucher or some sort of credit to the general public to buy basic health insurance. That would be a lot fairer and then people could add onto that.

It would probably mean a lower cost health care system with high quality for all Americans. So everyone would benefit, even some of the higher income people because the costs would be better controlled from the bottom up than we are able to do by our current approach. And I am glad to hear from you that there are some; it was totally unrealistic 10, 15, 20 years ago. There is increasing interest in looking at it.

The other area that is related to this is that we have gone through a major effort, and fairly successful, in trying to move people from the world of welfare to the world of work, but we still have a second big piece there. That is the low-income worker trap, because when you are getting Medicare, you are getting rent supplements, you are getting food stamps, and you are getting the earned income tax credit. Say you have two kids at minimum wages making $11,000 a year, hurray, and we raise that up and you make $15,000 a year. With all the phase-outs and your marginal tax rates, if you look at not just taxes, but all the benefit phase-outs, often is in excess of 100 percent. You are worse off when you raise the minimum wage or you do something for people in that category even with the best of intentions. Going to a health care voucher would be a major step toward breaking that and helping people.

Republicans are for supply-side economics. Incentives make a difference. Incentives are negative for people and very marginal for people in that $10- to $22,000 income range, and we have a major effort as a country to address that. If we can get health care right, it may help that a great deal.

But my question after that little speech is that at least in one version of your testimony, you were talking about the growing rate of people working for small businesses, and that we should be sensitive to trying to help small business employees get health coverage. Some of us have favored trying to help association plans so that people could band together through trade associations or others and get health insurance. Does that make sense with proper provisions, or should we continue to stand back and allow states to close those down because they don't meet various state insurance requirements?

And in that connection too, Mr. Risalvato, you didn't mention any gas station association plans. Do those exist in New Jersey, or is that an option you have worked with from time to time?

Ms. Chollet. Let me respond to your questions in several ways. I find it ironic that we are concerned about increasing costs at the margin when in fact the tax structure and the distribution of low-wage workers in this country are stacked so that that impact is maximized. The tax structure is presumably outside the purview of this Committee, and certainly the wage structure is not within your power, but the system is stacked to make cost increases have the maximum impact for low-wage workers who are predominantly

in small firms. The early version of our testimony, and I apologize for that confusion, had a problem in it and it was not clear.

Employment in small firms has not grown since 1990. In fact, employment in firms over 1,000 represents the greatest segment of growth in the work force. It is not in small firms. Nonetheless, low-wage workers are very concentrated in small firms. They are four times as likely to be in a firm of under 10 as are workers who earn $40,000 or more, so that wage distribution in small firms coupled with the high cost of insurance in small firms associated largely with administration and marketing are kind of a double whammy in the system.

The Association Health Plan proposal is problematic. On the one hand it is possible that firms could band together and bargain for a better set of benefits or a set of benefits that is better tailored to the needs of the particular employers and employees who have participated in the association. There has been absolutely no evidence that association plans or purchasing cooperatives as they have been established by any state or by any private organization have succeeded in significantly reducing the cost of health insurance.

The one place where these kinds of associations can save costs is in selective participation by employers who happen to have low-cost workers. So one of the largest concerns is that we would take an insurance market that already is unstable in some ways, struggling to keep costs down, and select out healthy workers, low-wage workers, young workers, put them in association plans where they will pay a rate that reflects their low risk, and everybody else has rising health care costs who cannot get into that association for whatever reasons. So that kind of bias selection problem is a big one even if these association plans can be made stable.

Mr. Risalvato. If I understand your question, you are asking me is there anything available to me right now in my industry, and I am not aware of any. I can just throw out an example. I am the President of the local business association in my community. I wonder what it would be like if I was able to bring all the businesses together in my community and go to various insurance companies and say, okay, I have this number of lives to ensure. Give me your best deal. I have to think there has got to be some kind of purchase power there.

Ms. Chollet. If Mr. Risalvato did that and bore all the marketing costs and all the administrative costs that the insurer otherwise would be incorporating, capitalizing on the cost of the health plan, yes, you would get a lower cost health plan, but you would be bearing those administrative costs directly as opposed to those costs through a health plan.

Chairman Boehner. Mr. Holt.

Mr. Holt. I wanted to get a little bit of the structure of the health plans beyond just the basic premium price, although I have a question about that, too. But first let me ask Dr. Chollet and Mr. Kahn in particular and others if you have comments.

I noticed when you talk about the increasing share of prescription drugs in the cost, it doesn't seem to correspond with a negative or decrease in the cost of hospitalization. I suspect there is probably some savings in hospitalization with increased

use of medications, and I am wondering whether your studies, it may be beyond the scope of your studies, show anything about the relationship between the coverage for prescription medication and the overall cost.

Ms. Chollet. I am not aware of a study that does that, although I would imagine we would find a negative correlation. I am not sure the causality would be strong.

Mr. Kahn. I don't have a study, but just from my anecdotes of discussions with people from the companies that I represent, my sense is that for given conditions there clearly is some substitution effect. I think the numbers bear this out in terms of overall costs. We still see hospital costs and physician costs increasing, so that I can't say that some of these added expenditures for prescriptions aren't helping us in reducing the other costs, but the other costs are still expanding.

Just to give you an example, I know with Ford Motor Company right now, I think that out of the $1.5 billion they spend directly on health care, 21 percent last year was hospital, and 19 percent was for drugs. Those numbers are going to cross, and the drugs are going to become a much larger percentage. A lot of that is for new drugs or replacement drugs that are more expensive than other drugs.

So it is very hard to come up with a substitution effect. Although clearly, without question whether it is the cholesterol drugs or other drugs, they are helpful to people and they provide better health care.

Mr. Holt. Mr. Risalvato says it is cost, cost, cost at least in the decision of what to offer. Although as you described your history, it sounds like it was not exclusively costs that led you to make the decisions of what to offer.

I would like to ask the other panelists in particular to comment. If you could list briefly, very briefly, the other factors that determine in your judgment and in your studies, whether employers offer the coverage and whether the factors that determine what employees choose in addition to just premium cost.

Ms. Chollet. It can be, in addition to costs, the adequacy of the benefit whether the benefit is perceived as so meager as not to be useful to the employee. This can be the perception about plans that have very narrow benefits, have very, very high deductibles relative to the ability of their employees to pay, don't have the generous offer Mr. Risalvato made, or have plans that have very low limits on coverage. It also can relate to the options that are available at a particular cost.

There is some evidence that after considering cost, employees when confronted with a managed care option like to have a provider that is known to them. So that can be an issue as well. There certainly is some evidence that if employers, and probably mostly employers, perceive their insurance option as something that is not stable or they are not able to sustain, for some reason they are much, much less interested in starting down that road. Cost probably accounts for the first three to five reasons.

Mr. Kahn. I think cost is clearly not the only factor in this decision-making process, because the numbers that were related earlier regarding the type of products that people want and employers are providing, the fact that the HMO kind of product is a little bit less popular and the PPO product is growing, and the PPO product is basically an open

network choice product and, as in almost all cases, is more expensive is telling you that even though cost is a factor, that employers and employees are willing to have more of their compensation spent on health to get that extra amount of choice.

So I think there are things going on here other than simply cost, and those trends and the type of products people are purchasing illustrate that.

Mr. Risalvato. Mr. Holt, if I could also just address what you commented on. Yes, I did stress cost, and you said that obviously there had to be other factors because I made the decision to still provide the benefits. So there were other things, and, yes, there were competitive factors.

But let me say this. It has been a great struggle, and I was willing to do that, whereas other employers may not have. I can also say that it may not have been a wise decision. I have struggled to keep my doors open for the last 2 years. I may not be in business 2 months from now. I have exhausted all avenues of taking on new capital. If I add up what I have spent in those years paying for my employees' health care and had that in a lump sum today, it is not even a thought. I have capitalization to continue my business.

So, yes, I still got past that cost factor, whereas other employers may not have. All that I am saying to this Committee is that you must consider that small business owners must take that into account. I did. I made my decision. I made my bed. I will lie in it, but cost is it.

Mr. Anderson. I will take a shot at that as well. Our decision as I think about health care; I guess I would step back and say we, as many companies, compete globally, and so we make decisions about where we invest, what we offer our employees, et cetera. It has really become complex in terms of how we address it. So for us the value of benefits, health care packages as well as total compensation is something we continually look at. The trade-off between costs and so on we will continue to struggle with. But as I said earlier, we also are very interested and concerned about the impact that health has on our employees, so we are trying to really balance a lot of issues. We are operating under this competitive market now that will drive us to continually look at this and probably have to make some of the trade-offs, more than we have had to make in the past.

Mr. Holt. Thank you, Mr. Chairman.

Chairman Boehner. Dr. Fletcher.

Dr. Fletcher. Thank you, Mr. Chairman. I certainly appreciate each of you and the testimonies. I know in my experience I have gone through the frustration of dealing with managed care. I understand why providers have a great deal of concern about making sure they can provide care for their patients without going through a great deal of bureaucracy or without refusal of being paid.

I think one of the things we focused on is we have looked at some of the Bills that Members of this Committee are proposing, making sure that those decisions are made by physicians, external review that is binding, and that it is physicians also attempting not to drive up the cost. I think as we have heard all of the discussion here, it seems like cost and choice come down really to a lot of the factors that influence an

individual whether they purchase the insurance and take the option that the employers have given them, or whether they don't.

Let me ask some questions. Mr. Anderson, I just want to say you all have a plant that makes all of the Post-It notes in our District, and we appreciate that. I visited there and talked to many of the employees. You provide excellent health care, and I know if they have got a problem that the insurance may not want to cover, they go talk to the folks there, and they get it covered and do an excellent job. They haven't had any problems with that. So I know it is the very responsible employer members we have in this country that provide most of the insurance, and I appreciate that.

Dr. Chollet, I think we share very similar concerns, as to how we get the low-income individuals covered? Let me ask you about something. Have you reviewed the association health plans legislation that has been presented? I think Mr. Talent introduced that.

Ms. Chollet. No sir not in detail.

Dr. Fletcher. I think one of the things you may find that you will be very pleased with is the fact that it doesn't allow selection as you talked about. As a group comes in, an employer group, they have to take all comers so they can't do the selection that you are talking about. Basically it would be a guaranteed issue for that group. So I think we have addressed many of the concerns that you will find you would be very favorable toward.

We did legislation in Kentucky. One of the things they did which I actually disagreed with is they carved out Associations from some of the mandates in the state. The reason they did that is because of lobbying by the Associations, because they realized that they saved a great deal of money by forming the Associations. So clearly I think the market understands that. People understand if they can do that.

If Mr. Risalvato could look at NFIB, or maybe one of the other Associations that he may be a member of or have access to and join with them and purchase there where they have already had the administrative costs, do you think that would decrease the cost for him and allow him and businesses like him to cover more individuals?

Ms. Chollet. Once again sir, if there is another party bearing these administrative costs and in effect, subsidizing the employer to participate so that the insurer is not incorporating the administrative costs of marketing and enrollment and dis-enrollment. If some other party is doing that, and the employer is not paying for that, then yes, it will give you lesser cost insurance for a small firm.

Dr. Fletcher. Let me take your recommendation and give it to Mr. Anderson.

Mr. Anderson, from what we have heard, you probably ought to provide insurance on a local basis because your administrative costs for combining and doing some larger negotiation are much increased. I mean, that is of what I am hearing. In other words, because of the administrative costs, the Associations are making sure that they do the marketing. Then the Associated Health Plans have to actively market to all those individuals. You know, surely the gains of an economy of scale can be realized.

I would encourage you to take another look at the Association Health Plan, because I think it does help address the concerns that we both have. I am sure it is not perfect. Nothing we do is, but I hope it answers that.

Mr. Risalvato, I just appreciated your testimony. You know, I wish we could just hear the resounding clarity of small business folks that are struggling to do the right thing like you have done. That is provide some tax reform, and provide some opportunities for small business and other folks to offer the kind of insurance that you have done and , obviously made the sacrifice for it. So I just wanted to thank you for your testimony.

Mr. Risalvato. I thank you for thanking me.

One of the things that is very, very important to myself and my small business colleagues is the fact that sometimes we feel as if we get the blame for this. Not only do I think we should not get the blame, I think there should be considerable appreciation and thanks for exactly what we have done.

I would like to add that the National Federation of Independent Business has a study that will show the benefit of significant cost savings by the AAHPs that would be in direct contrast to Dr. Chollet.

Dr. Fletcher. Thank you very much.

Chairman Boehner. Mr. Kahn, as you and Mr. Andrews were asking and answering questions about the Patient's Bill of Rights and the Dingell Bill, it was obvious to me you know an awful lot about it and must have reviewed it. Can you tell me what the impact of the Dingell Bill would be on the Federal Employees Health Plan or on Medicare?

Mr. Kahn. Well, it would be extremely significant in two respects. One, medical necessity in Medicare, historically since the beginning of the program, has been controlled by HCFA, the agency operating Medicare. There is no discussion of that being passed off to providers and beneficiaries, albeit beneficiaries can appeal in Medicare if they have a problem with a decision. It is Medicare that makes the final decision.

Second, in terms of liability, Medicare is the government. So in both cases and in the case of the Federal Employees Plan, I don't believe that it will be affordable to apply all of the aspects of the Dingell Bill to it either.

Chairman Boehner. Does it apply? Does the Dingell Bill apply to the Federal Employees Health Plan?

Mr. Kahn. No, it does not apply. The issue of medical necessity and liability are outside of law, and so it doesn't apply.

Chairman Boehner. Why would it apply to all employers and all people in private insurance markets around the country, but not to the Federal Employee Health System or Medicare?

Mr. Kahn. Well, we think it would be better if it was not done and didn't apply anywhere.

Chairman Boehner. I understand that.

Mr. Kahn. I guess the question of equity would immediately emerge. That is why I think there would be great reticence in opening up Medicare to the same rules that you would expect to apply to the Federal side in that bill.

Mr. Andrews. If the gentleman would just yield for a second, I can take a shot at answering his question.

Subject to whatever limitations of sovereign immunity might arise, decisions by Medicare or by HCFA are not protected by any sort of tort immunity now. If someone feels the federal government has made an improper decision, they have the right to sue them now. We just simply equalize the situation.

Could I ask Mr. Kahn another question?

Chairman Boehner. Yes.

Mr. Andrews. I was very interested in the statement that one out of every four uninsured people in America is uninsured because of state health benefit mandates. That is in your written statement.

Mr. Kahn. That would be the analysis from Jensen and Morrisey.

Mr. Andrews. Do you agree with that conclusion?

Mr. Kahn. I think there is a relationship, and we believe there is a relationship between costs and no insurance, and that is the Jensen and Morrisey conclusion.

Mr. Andrews. Could you just describe to me the way by which that is derived? What is the assumption? How much and what percentage of the premium cost is allocated to state mandates?

Mr. Kahn. Well, the point is that the state mandates increase in cost, and CBO has produced analysis that indicates how many people are uninsured at each additional percentage of cost. That is the analysis of Jensen and Morrisey.

Mr. Andrews. Do they assume that state mandates are responsible for 20 percent, 30 percent, 15 percent? What is it? Do you know what it is?

Mr. Kahn. We gave a percentage that was the percentage at the margin that Jensen and Morrisey projected. It was one in four.

Mr. Andrews. If you take that conclusion, it implicitly states that if we abolish all these State mandates, just got rid of them, the price would drop by some number. The price of health insurance would drop by some number. What is that number? What is the study based on?

Mr. Kahn. Well, it would vary from state to state, but the number would be significant and pick up hundreds of thousands, if not millions, of more people. That is the answer.

Mr. Andrews. I would give you the opportunity to supplement the record.

Mr. Kahn. I would be happy to.

It would vary from state to state because, as the study indicates, the number of mandates vary from state to state. There are some states with a small number of mandates, and there are others with tens of mandates. So we will be happy to do that.

Mr. Andrews. I would be interested in the answer. Thank you very much, Mr. Chairman.

Ms. Cassidy. I have the answer to that question for Maryland, which is a heavily mandated state for health insurance benefits. Our estimate is that the cost of mandates is about $600 per policy per year, or about 15 percent of the policy cost for the year.

Mr. Andrews. Fifteen percent of the policy cost. So if Maryland were to adopt a statute repealing its mandates, what kind of mandates are we talking about here?

Ms. Cassidy. Everything from minimum stay for maternity, to mental health parity, to all of the medical-related insurance mandates.

Mr. Andrews. So if Maryland were to pass a law that says you can sell a health insurance policy without any mandatory coverage at all, just whatever can be negotiated between the buyer and the seller, it is your conclusion that it would be a 15 percent reduction in the premium?

Ms. Cassidy. [Nodding in the affirmative.]

Mr. Andrews. Again, I would offer Mr. Kahn the chance to supplement the record that way.

Mr. Kahn. If I could add a point. In Maryland the State Legislature, I think, became so antsy over time about the number of mandates they had added, that they have even set up a medical board to give them advice. This is because many of these mandates are not simply to cover various kinds of conditions, but they are provider mandates so that chiropractic and other kinds of services would be covered. It is not simply disease-oriented. It is also provider-driven. I think that is another important point.

Ms. Cassidy. Over 20 of them were introduced this year.

Chairman Boehner. Didn't Maryland finally pass a statute that said that if they were going to add another mandate, they had to drop one? Is that correct, Mr. Kahn?

Mr. Kahn. Yes.

Mr. Andrews. I assume, Ms. Cassidy, these are non-ERISA plans we are talking about, right?

Ms. Cassidy. Yes. They would be insured plans, yes.

Mr. Andrews. Do you know what percentage of covered lives in Maryland are non-ERISA plans?

Ms. Cassidy. I do not.

Mr. Andrews. I would be interested in that answer, the question being is the sample large enough to draw a valid conclusion.

Mr. Kahn. I don't know in Maryland per se, but from our research, we believe that about 50 percent of employer plans are self-insured. The other 50 percent are not, so that they would be subject to state regulation.

Chairman Boehner. In my experience as a state legislator on the insurance committee, about half the lives in the state were covered by self-funded plans.

Mr. Andrews. But this is in Ohio, right? That is hardly a conclusion one can apply to the rest of the country.

Chairman Boehner. I want to thank my colleagues for coming today. I want to thank all of you for coming, especially our witnesses, and we will see, I am sure, most of you next week. We are adjourned.

Whereupon, at 12 noon, the Subcommittee was adjourned.

APPENDIX A - WRITTEN OPENING STATEMENT OF CHAIRMAN JOHN BOEHNER, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
COMMITTEE ON EDUCATION AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

Opening Statement

The Honorable John A. Boehner
Chairman
Subcommittee on Employer-Employee Relations

Hearing on
"The Relationship Between Health Care Costs and America's Uninsured"
June 11, 1999

"Welcome to all and especially to the Witnesses. We appreciate all of you making the effort to be here today to help us understand exactly what is happening in the health insurance market place today as it relates to cost and coverage.

"This hearing is part of our continuing effort to provide the proper context for this subcommittee as we prepare to take on the issue of patient protections. In our previous hearings, we have looked at ERISA and how it works, health plan claim review procedures, and proposals for external review of denied claims. In addition, we have looked at one option to reduce costs and provide coverage, known as association health plans.

"But no matter how each of us feels about ERISA, or claims review, or group purchasing, on this we can agree: we should not move forward on any change without first having a grasp of current private sector health care trends – both in terms of cost and availability of insurance. And that is what I hope we can accomplish today.

"After a long bout with double-digit premium increases in the 1980s, it was widely believed that by the mid-1990s, the cost problem had largely been defeated. Through the growth of managed care, premiums stabilized and in many cases were growing at a rate beneath inflation. Now, as our witnesses will tell us, I believe we have turned another corner, with studies showing premiums on the rise again.

"It is not hard to follow the reaction of Congress to each phase of these trends. When premiums were rising in the 80s and early 90s and the number of uninsured approached 40 million, we had a great debate about cost containment and universal coverage. After 1994, when costs stabilized, many policymakers turned their attention from those who do not have insurance to the quality of insurance for those who do have it.

Hence, the passage of the insurance portability law and our ongoing focus on patient protections.

"Now, with premiums on the rise and the number of uninsured at 43 million and rising, we have no choice but to consider these problems in tandem – patient protections on the one hand, cost and coverage on the other. This subcommittee will consider proposals next week that I believe deal with both in a measured, balanced way.

"I have said at previous hearings that we must be aware of the trade offs that occur when we place additional regulation on employer sponsored health plans. More regulation means higher costs, and higher costs means reduced coverage. We may differ on the degree of that phenomenon, but I think we all acknowledge it exists.

"As we begin the legislative process of managing those trade-offs, I thought it would be particularly appropriate for our witnesses to describe to us the atmosphere is which we will be making these decisions. I should emphasize that these witnesses have not been asked to solve all of our policy challenges in their testimony – again, they will tell us what is happening out there, plain and simple, on the issue of cost and coverage, and why it is happening. I would ask the members to focus on that as well.

"Thank you for being here and we look forward to hearing your testimony."

APPENDIX B - WRITTEN STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, D.C.

CBO TESTIMONY

Statement of
Dan L. Crippen
Director
Congressional Budget Office

on
Health Care Costs and Insurance Coverage

before the
Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives

June 11, 1999

NOTICE

This statement is not available for public release until it is delivered at 9:30 a.m. (EDT), Friday, June 11, 1999.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Mr. Chairman and Members of the Committee, I am pleased to be here today to discuss the relationship between health care costs and insurance coverage. Despite several factors that might boost health insurance coverage—such as the booming economy, expansions in Medicaid eligibility, state insurance reforms, federal legislation to improve the portability of health insurance, and several years of slow growth in health insurance premiums—the percentage of Americans who lack health insurance has grown. The number of people without insurance is likely to continue to increase, although that growth will be moderated by federal and state initiatives to expand coverage (such as the State Children's Health Insurance Program). Health insurance premiums will grow more rapidly than in the recent past, and more low-income families will move off the welfare rolls and Medicaid into entry-level jobs that do not offer coverage. Policies that further increase health care costs and premiums could result in larger reductions in insurance coverage than might otherwise occur.

My testimony today will outline what we know about the characteristics of the uninsured population and describe recent trends in health care costs and insurance coverage. Most of my remarks will focus on how policies that mandate benefits or impose other standards on health plans may contribute to higher premiums and lower coverage rates.

CHARACTERISTICS OF THE UNINSURED POPULATION

According to the Current Population Survey (CPS), about 43 million people under age 65 lacked insurance coverage in 1997.[1] That estimate represented 18.3 percent of the nonelderly population and compares with 14.8 percent who lacked coverage a decade earlier. Most uninsured people were in working families, and one-quarter of them were children. More than half of them were in families with income below 200 percent of the poverty level.

Low-wage workers and those in small firms are much more likely to lack coverage than other workers. Most low-wage workers with access to employer-sponsored coverage—either through their own employer or that of a family member—enroll in employer-sponsored plans. But they are much less likely than other workers to have access to employer-sponsored coverage from any source. In 1996, for example, 55 percent of workers earning up to $7.00 an hour had access to employer-sponsored coverage from any source compared with 96 percent of workers earning more than $15.00 an hour. Similarly, 63 percent of workers in firms with fewer than 10 employees had access to such coverage compared with 93 percent of workers in firms with more than 100 employees.[2]

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1. Paul Fronstin, "Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1998 Current Population Survey," *EBRI Issue Brief*, no. 204 (Washington, D.C.: Employee Benefits Research Institute, December 1998).

2. Philip F. Cooper and Barbara Steinberg Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," *Health Affairs*, vol. 16, no. 6 (November/ December 1997), pp. 142-148.

The percentage of the population that is uninsured varies widely among the states, ranging from less than 15 percent in most midwestern and New England states to more than 20 percent in California and some of the southwestern states. That variation reflects differences in population characteristics, such as per capita income and the proportion of recent immigrants, and in labor force characteristics, such as the distribution of workers among different industries and the extent of unionization. States also differ in their policies regarding Medicaid eligibility, rules relating to the accessibility and affordability of coverage in the small-group market, and the extent to which they impose benefit mandates and other requirements on health insurance.

TRENDS IN HEALTH CARE COSTS AND INSURANCE COVERAGE

Competition among health plans, and the associated shift from indemnity to managed care plans, contributed to a dramatic slowdown in the growth of health insurance premiums in the 1990s. On average, the annual rate of increase in premiums fell from double-digit levels in the late 1980s and early 1990s to 2 percent or less in 1995 through 1997. Over the past year, however, premiums have begun to grow more rapidly again as health plans that had held down premiums to capture a larger market share seek to improve their profit margins. Some analysts and health plans are predicting increases in the range of 6 percent to 10 percent in both 1999 and 2000. Others are predicting even larger hikes.

Rates of insurance coverage for both adults and children declined over the 1987-1997 period, and that decline appears to be continuing. Data from the CPS indicate that coverage of nonelderly adults fell fairly steadily until 1992 and then remained relatively stable before declining again in 1997. The percentage of nonelderly adults who were uninsured rose from 15.6 percent to 19.7 percent during the period. Coverage of children increased slightly from 1987 to 1992 and then started to fall. In 1997, 15 percent of children were uninsured.

Analysis based on the CPS suggests that the reductions in coverage rates that occurred between 1987 and 1992—a period in which premiums were growing rapidly—were attributable primarily to lower rates of employer-sponsored insurance.[3] One cannot, however, infer causality solely on the basis of that apparent association. Subsequent declines appeared to be attributable mainly to falling rates of Medicaid coverage, with the proportion of the population with employer-sponsored insurance remaining relatively steady through 1997.

Another recent study, which was based on data from other surveys taken in 1987 and 1996, found that the proportion of workers with employment-based coverage from any source fell from 76.2 percent to 73.2 percent over that period.[4] The study suggested that the decline generally resulted from lower rates of

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3. Fronstin, "Sources of Health Insurance."

4. Cooper and Schone, "More Offers, Fewer Takers." This study uses data from the National Medical Expenditure Survey, 1987, and the Medical Expenditure Panel Survey, 1996.

participation in employer-sponsored plans rather than reductions in the rate at which employers offer coverage. For low-wage and young (under age 25) workers, however, the proportion with access to employer-sponsored coverage (through their own job or that of another worker in the family) fell, as did their participation rates.

IMPACT OF INCREASING PREMIUMS ON COVERAGE

Health care costs are rising for many reasons including changes in medical practice, the development of costly new technologies, and greater use of prescription drugs and other services. A 1998 article in the *Wall Street Journal*, for example, described some of the new high-cost technologies that had recently come onto the market.[5] They included new brain surgery techniques for treating Parkinson's disease, three different $10,000-a-year drugs for treating multiple sclerosis, and improved inhalers for asthma patients that cost three times as much as other inhalers. Technological breakthroughs are also resulting in a wide range of powerful new drugs including antidepressants, medications for acquired immunodeficiency syndrome (AIDS), and drugs for reducing cholesterol levels. Demand for such drugs is being driven in part by direct-to-consumer advertising, and many health plans are reporting that their drug

5. Ron Winslow, " Health Care Inflation Revives in Minneapolis Despite Cost-Cutting," *Wall Street Journal*, May 19, 1998.

costs are soaring. Those rising costs are redistributed in the health care system in various ways including changes in covered health insurance benefits, higher premiums for health insurance, and reductions in coverage.

Government regulation at both the state and federal levels can also increase the costs of health insurance and lead to higher premiums. Examples of such regulations include:

- o Mandates to cover specific benefits such as chiropractic services or minimum hospital stays for births;

- o Regulations to change the way in which health plans operate—for example, requiring appeals procedures when benefits are denied or reducing insurers' ability to reject applicants with preexisting conditions; and

- o Taxes on health insurance premiums.

States also regulate the premiums that insurers charge for health policies, often by requiring premiums charged to small firms to fall within specified limits. Such regulation is frequently thought to keep premiums affordable for employees in

those firms. Higher-risk groups have lower insurance costs because of the upper premium limit. But the lower premium limit is generally higher than insurers would charge to the good risks—people who are healthier and less likely to use health services. Consequently, the good risks tend to drop their coverage, which raises the average cost of insurance for those who remain in the small-group market.

The Congressional Budget Office (CBO) assesses the likely private-sector costs of proposed federal mandates on health insurers and health plans as part of its duties under the Unfunded Mandates Reform Act of 1995 (UMRA). The act requires CBO to estimate the aggregate amount that private-sector entities would have to spend to comply with the mandates, assuming that such entities take all reasonable steps to mitigate those costs. CBO's analysis is limited to the costs of the proposed legislation and does not consider its benefits. In recent years, CBO has analyzed proposals to require parity in the provision of mental health services, to ensure access and portability of insurance coverage, and, more recently, to expand patients' rights.

CBO's analysis of a proposed health insurance mandate takes into account how employers who offer health coverage would react to the additional costs imposed by the mandate. Employers might respond to such costs by reducing the generosity of insurance coverage, perhaps by raising cost-sharing requirements imposed on beneficiaries or by eliminating some benefits. Some employers might

drop health coverage altogether. They might also reduce the generosity of other employee benefits or the size of wage increases. Such actions limit the rise in labor costs that would otherwise occur because of an insurance mandate.

Employees and others buying insurance in the individual market would also respond to rising health insurance costs. Some would drop their coverage as premiums increased, while others would select less generous coverage if that option was available. Even beneficiaries who retained their health coverage without change after enactment of an insurance mandate would be affected, since their costs would increase.

In general, higher premiums are likely to result in some loss of coverage, although the magnitude of the reduction is difficult to predict. One should be cautious, however, about applying a single rule of thumb to assess the effects on coverage of changes in premiums that arise from different sources. Any mandate on health insurance that raises premiums, for example, could cause some decline in coverage—just as an increase in the price of any product could cause demand for that product to fall. But the specific nature of any insurance mandate will affect its impact on coverage. Consequently, potential declines in coverage can be estimated only by analyzing specific legislative proposals individually.

In particular, the loss of coverage that is likely to result from imposing an insurance mandate depends on a number of factors including the following (to simplify the discussion, consider a mandate to add a new benefit):

- A mandated benefit that is highly valued by consumers would cause fewer people to lose insurance coverage than a benefit of lower value having the same cost.

- A mandated benefit that is already offered by many health plans on a voluntary basis would cause fewer people to lose coverage than a benefit that is not commonly offered.

- Some states may already require the mandated benefit, which would lower the impact of the mandate for the nation as a whole. (Employer plans that are fully insured must comply with states' benefit mandates, but those that are self-insured are exempt from those mandates under the Employee Retirement and Income Security Act of 1974, or ERISA .

- A mandate that primarily affects insurance offered by large firms would be expected to lead to a smaller decline in coverage than one

that primarily affects small firms. Small firms and their workers are more sensitive to premium increases and are more likely to drop coverage because of a mandate.

CONCLUSION

The number of people without health insurance continues to grow despite the booming economy, expansions in Medicaid eligibility, and other efforts to increase insurance coverage. Rising health care costs have made insurance less affordable for many Americans. Proposals that would impose new mandates on health plans and insurers are meant to improve the value of insurance to consumers, but they could also raise insurance costs and exacerbate the problem of growing numbers of the uninsured. Other proposals are intended to increase health insurance coverage by creating a less regulated environment in the small-group market through such vehicles as association health plans and health marts. Although those proposals could encourage the entry of some lower-cost health plans into the health insurance market, they might also decrease coverage among high-risk groups. Balancing the advantages and disadvantages of competing policies is a significant challenge facing the Congress in the months ahead.

APPENDIX C - WRITTEN STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH FINANCING AND PUBLIC HEALTH ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE, WASHINGTON, D.C

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Employer-Employee Relations, House Committee on Education and the Workforce

For Release on Delivery
Expected at 9:30 a.m.
Friday, June 11, 1999

PRIVATE HEALTH INSURANCE

Impact of Premium Increases on Number of Covered Individuals is Uncertain

Statement of William J. Scanlon, Director,
Health Financing and Public Health Issues
Health, Education, and Human Services Division

GAO/T-HEHS-99-147

Mr. Chairman and Members of the Committee:

Approximately 150 million individuals obtained health insurance through the workplace in 1996, either through their own employer or the employer of a family member. During the last several years, an increasing number of these individuals have enrolled in some form of managed care rather than in fee-for-service plans. Recently, concerns have grown regarding the ways in which some managed care plans operate and the adequacy of information shared between each plan, its providers, and its members.

In response to these concerns, several legislative proposals have been made to require health insurance plans to adopt specified operational practices. The proposals apply to all types of plans but would likely have their greatest impact on health maintenance organizations (HMO). Other types of plans—such as preferred provider organizations (PPO) and indemnity, or fee-for-service plans—will likely be affected to a lesser degree. Included in the various proposals are requirements, for example, to disclose certain information,[1] guarantee patient access to emergency and specialty services, implement internal and external grievance policies, and guarantee freedom of communication between providers and patients. Some lawmakers are concerned, however, that these types of mandates could increase the cost of health insurance and have the unintended consequence of reducing the number of individuals covered by private health insurance.

To help inform congressional consideration of these proposals, you asked us to present the findings of a study we did for Senator Jeffords last July that analyzed the relationship between private insurance premium increases and changes in the number of covered lives.[2] My remarks today are based on that study. Specifically, I will focus on (1) the trends in employers' decisions to offer insurance and employees' decisions to purchase it, (2) an assessment of recent studies that have estimated the relationship between premium increases and insurance

[1]Legislative proposals would require each plan to disclose, for example, information on appeal procedures, restrictions on reimbursement for care received outside of the plan's network of providers, and the location of plan providers and facilities.

[2]Private Health Insurance: Impact of Premium Increases on the Number of Covered Individuals Is Uncertain, (July 7, 1998, GAO/HEHS-98-203R).

coverage, and (3) conditions or factors that could affect the impact of premium increases on insurance coverage.

In summary, from the late 1980s to the mid-1990s—a period of rising health insurance premiums—the proportion of employees offered coverage rose from about 72 percent to 75 percent, while the share that accepted insurance fell from approximately 88 percent to 80 percent. The extent to which various factors contributed to the fall in the acceptance rate is unclear. It may have resulted from employees being asked to pay a larger share of the premiums or other factors, such as decreases in some workers' real income. Medicaid-eligibility expansions and changes in benefit levels also may have contributed to the fall in the acceptance rate.

Few studies have attempted to estimate the effects of premium increases on insurance coverage, and no study adequately estimates the coverage loss that might result from new legislative mandates. Studies by the Lewin Group, for example, suggest that 300,000 to 400,000 individuals might drop or lose insurance coverage if premiums increased 1 percent. However, these estimates assume across-the-board premium increases. The potential coverage loss might be much lower if mandates primarily affect HMO premiums and employers and employees can switch to different types of coverage. Furthermore, serious data limitations affect the precision of many of these studies' estimates.

Finally, many factors can affect the impact that health insurance mandates have on the number of individuals covered by private insurance. For example, if new mandates result in changes that individuals consider worthwhile, they may be willing to pay higher premiums. The extent to which employers pass on premium increases to employees, employees' opportunities to switch to less expensive plans, and changes in economic factors—such as income, or changes in public insurance program eligibility requirements—can also affect the number of individuals with private health insurance.

BACKGROUND

Between 1995 and 1997, real health insurance premiums (adjusted for inflation) remained nearly constant or fell slightly across all plan types. (See table 1.) This represents a sharp decline from the previous 5 years, in which inflation-adjusted growth was as high as 11.6 percent for indemnity plans and 10.6 percent for HMOs in 1990. In 1998, premiums increased for all insurance types, but the increase was much lower than was experienced in the early 1990s.

Table 1: Percentage of Real Annual Growth in Premiums, by Type of Health Plan, 1991-98

Plan type	1991	1992	1993	1994	1995	1996	1997	1998
Indemnity	7.8	8.0	5.5	2.5	-0.1	-1.8	0.3	1.9
PPO	5.9	7.6	5.2	0.6	0.7	-2.4	-0.2	2.3
HMO	7.9	6.8	5.3	2.7	-2.4	-3.4	-0.3	1.3

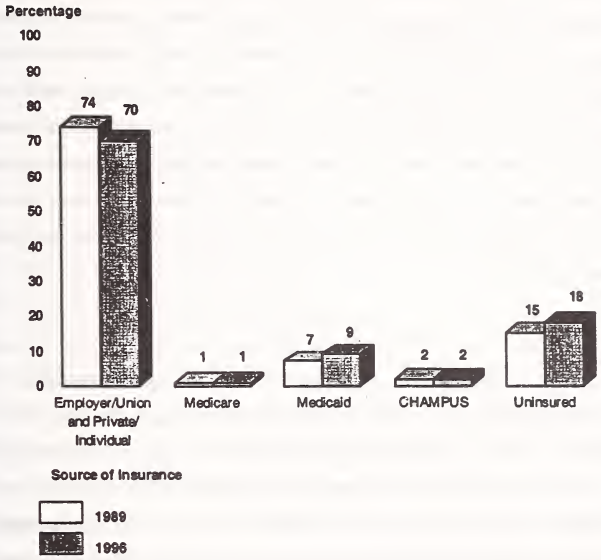
Sources: GAO calculations based on data from KPMG Peat Marwick (1991-98) and Bureau of Labor Statistics Consumer Price Index. Includes employer and employee shares of premiums for workers in private firms with at least 200 employees.

About 70 percent of the population under age 65 was covered by health insurance purchased through an employer or union, or purchased privately as an individual in 1996, according to Current Population Survey (CPS) data. About 12 percent was covered by Medicare, Medicaid, or the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and about 18 percent was uninsured. From 1989 to 1996, the percentage of the population covered by employer-sponsored, union-sponsored, or individual insurance[3] decreased slightly, but these

[3]Individual insurance is coverage that an individual purchases directly from an insurer or through a broker.

options still remained a prominant source of coverage for people under age 65. (See fig. 1.) During the same period, the proportion of the population covered by Medicaid and the proportion without insurance both increased.

Figure 1: Sources of Health Insurance for People Under Age 65, 1989 and 1996



Sources: U.S. Bureau of the Census, CPS (March 1989-March 1997).

MORE WORKERS WERE OFFERED INSURANCE, BUT FEWER ACCEPTED COVERAGE AS PREMIUMS INCREASED

Recent studies suggest that employers typically do not stop offering health insurance when premiums increase. Between 1988 and 1996, health insurance premiums-unadjusted for inflation-increased by about 8 percent per year on average. During approximately the same time period, one study[4] found that the fraction of workers offered insurance by their employers grew slightly, from 72.4 percent to 75.4 percent. The proportion of workers who had access to employer-sponsored insurance, either through their own job or the job of a family member, remained essentially constant at about 82 percent. Another study[5] reported that the fraction of small firms (those with fewer than 200 employees) offering insurance coverage grew from 46 percent in 1989 to 49 percent in 1996. The study also found that 99 percent of large firms offered insurance in 1996.

Fewer workers, however, are choosing to accept employer-sponsored coverage for themselves or their dependents. In 1987, 88.3 percent of workers accepted coverage when their employers offered it. In 1996, only 80.1 percent of workers accepted coverage. The fall in the acceptance rate was relatively large for workers under age 25 (from 86.5 percent to 70.1 percent) and those making $7 per hour or less (from 79.7 percent to 63.2 percent). The fraction of workers who accepted employer-sponsored insurance either through their own job or that of a family member also declined, from 93.2 percent to 89.1 percent. Consequently, even though a greater percentage of employers offered insurance, a smaller proportion of workers was covered by employer-sponsored insurance in 1996 compared with 1987.

The fall in the acceptance rate may be attributable partly to required increases in employees' insurance premium contributions. One study found that employees in small firms paid an average of 12 percent of single coverage premiums in 1988 and employees in large firms paid

[4]P. Cooper and B. Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996," Health Affairs 16(6) (Nov./Dec. 1997)

13 percent.[6] In 1996, the employee share had risen to 33 percent in small firms and 22 percent in large firms. According to the Lewin Group, the combined effect of the increase in premiums and the increase in the employees' share of those premiums resulted in workers paying 189 percent more in real terms for single coverage and 85 percent more in real terms for family coverage in 1996 compared with 1988.

Other factors also may have contributed to the drop in the acceptance rate. A decline in real wages for some workers may have made coverage less affordable. Expansions in Medicaid eligibility provided a coverage alternative for some families and may have decreased workers' willingness to accept employer-sponsored insurance. Furthermore, possible changes in benefit packages may have made coverage less desirable.

DESIGN OF STUDIES LIMITS THEIR ABILITY TO PREDICT POTENTIAL COVERAGE LOSS FROM NEW HEALTH INSURANCE REQUIRMENTS

Relatively few studies have analyzed the relationship between an increase in the cost of insurance and the change in the number of individuals covered. Several studies have examined the extent to which insurance premium subsidies might affect employers' decisions to offer insurance, but these results do not directly address the question of how much coverage loss might arise from an increase in premiums. The relevance of two studies that attempted to answer this question is limited, because of implicit assumptions embedded in the studies' designs and shortcomings in the available data.

In November 1997, the Lewin Group estimated that 400,000 fewer people might be covered by health insurance if new legislation caused premiums to rise by 1 percent.[7] Its estimate was largely based on studies of the effects of insurance premium subsidies on employers' decisions

[5]P. Ginsburg, J. Gabel, and K. Hunt, "Tracking Small-Firm Coverage, 1989-1996," Health Affairs 17(1) (Jan./Feb. 1998).
[6]J. Gabel, P. Ginsburg, and K. Hunt, "Small Employers and Their Health Benefits, 1988-1996: An Awkward Adolescence," Health Affairs 16(5) (Sept./Oct. 1997)
[7]John F. Sheils letter to Richard Smith, Nov. 17, 1997.

to offer insurance. These studies focused primarily on small employers and varied widely both in their research questions and their findings. The Lewin Group selected a midpoint estimate from a range of estimates it judged to be the best available. It then adjusted the estimate to account for the likelihood that individuals might obtain insurance through the policies of working family members, the individual insurance market, or public insurance programs if premiums rose on their employer-sponsored policies. However, the Lewin Group's estimate of potential coverage loss did not consider the possibility that employers or employees might switch to different types of insurance products if one type became relatively more expensive. Because many of the proposed federal mandates are expected primarily to affect HMOs and have little or no impact on PPOs and indemnity plans, Lewin's estimate may overstate the potential coverage reduction.

To correct for some shortcomings of its earlier study, the Lewin Group performed its own data analysis and released the findings in January 1998. The results indicated a lower potential coverage loss of 300,000 individuals for every 1 percent increase in premiums.[8] The findings of the 1998 Lewin Group's analysis, however, may have been affected by data limitations. Specifically, the analysis rests on an accurate measure of health insurance premiums paid by employees. Because this information was unavailable, the Lewin Group had to impute this amount. In addition, two aspects of the study's design limit its ability to predict insurance coverage reductions that might result from new legislative mandates. First, the coverage loss estimate—just as in the first study—applies to situations where all premiums increase by 1 percent. A 1-percent increase in HMO premiums would likely result in a smaller coverage reduction if employers and employees switched to other types of health coverage. Second, the Lewin Group explicitly assumed that all observed coverage changes resulted from employees' decisions to not accept coverage.[9] This assumption is broadly supported by findings from other

[8]The new estimate was based on the Lewin Group's statistical analysis of the relationship between what employees paid for insurance and the probability that they, their spouses, and their dependent children would have employer-sponsored health insurance. Lewin used complex statistical models to estimate the proportion of the population covered by employer-sponsored insurance grouped by a number of demographic characteristics, including race, age, income, full-time/part-time status, occupation, industry, firm size, and the imputed employee share of the premium costs, among others.

[9]The data used in the Lewin study do not indicate whether observed coverage losses are the result of employers' decisions not to offer insurance or employees' decisions not to accept it.

studies. However, to the extent that some employers decided to no longer offer insurance, the Lewin Group's estimate incorrectly predicts employees' reactions to changes in premiums.

MULTIPLE FACTORS AFFECT POTENTIAL IMPACT OF PREMIUM INCREASES ON NUMBER OF COVERED INDIVIDUALS

Insufficient information is currently available to predict accurately the reduction in the number of individuals covered by private insurance (referred to as coverage changes) that may result from health insurance premium increases associated with new federal mandates. One problem is that estimates of the effects of mandates on premiums have some uncertainty. However, even if the premium increase was known with certainty, previous research and economic theory suggest that the impact on coverage depends on a number of conditions. Coverage changes will depend on the extent to which premiums rise for employees and whether they can switch to insurance plans less affected by the mandates. The specific policy adopted also can affect how employees respond to resulting premium increases. Finally, changes in many economic and other factors can cause coverage changes that mask or exaggerate the impact of premium increases. The following list describes several conditions that could affect observed changes in health insurance coverage if new federal mandates increase insurance costs.

1. The percentage of premiums paid by employees and the amount of any premium increase that employers pass on to employees. If, as recent evidence suggests, employees' decisions largely affect the extent of coverage, then the relevant price increase is the percentage increase in their contribution. For example, about two-thirds of employees in small firms had to contribute toward premium costs in 1996. Those employees paid about 50 percent of the total premium. If total premiums rise by 1 percent and employers pass on the full increase to employees, then the employees' contribution would rise by 2 percent.

2. The extent to which additional benefits are valued by consumers. If higher insurance premiums are the result of additional benefits that consumers value, then any coverage loss will

be less than the coverage loss that might occur if premiums increased but benefits stayed the same (or the additional benefits had little consumer value). In its November 1997 letter, the Lewin Group notes that its "estimates of the number of persons losing coverage will differ depending upon the health policy being analyzed." The Lewin Group goes on to suggest that "some proposals that increase premium costs are often associated with other provisions that may either lessen or intensify incentives for individuals to drop coverage."

3. The extent to which employees can switch plans that have no or low premium increases. Proposed new federal mandates are expected primarily to increase costs of HMOs. Faced with a rise in HMO premiums, some employees may switch to PPOs or indemnity insurance rather than drop coverage entirely.

4. Changes in other insurance benefits. Instead of raising premiums in response to new mandated benefits, insurance companies and employers may find ways to reduce other parts of the insurance package to keep premiums constant. It is unknown how employees might respond to such changes in their insurance plans.

5. Changes in real wages and other factors. Changes in economic conditions or eligibility for public insurance programs can also affect private insurance coverage. For example, the Lewin Group estimated that a 1-percent rise in real incomes could increase private insurance coverage by nearly 0.37 percent (about 550,000 workers and dependents). Likewise, expansions in Medicaid eligibility could cause some workers to substitute public insurance for employer-sponsored family coverage.

CONCLUSIONS

The extent to which new legislative requirements for health insurance providers could ultimately affect the number of individuals with insurance coverage depends on the answers to several questions. To what extent will insurers raise premiums? Will fewer employers offer coverage to their employees or will employers pass some or all of the increased premium costs

onto their employees? How many employees will decline offered coverage if they must pay higher premiums?

The available studies offer only limited insights into these issues and illustrate the difficulty of estimating how the number of individuals covered by health insurance might be affected. Many of the studies we reviewed were hampered by incomplete data. Moreover, the design of the studies and the assumptions they incorporated limits their applicability to the current issue. Studies by the Lewin Group, for example, estimate coverage loss that might result from an across-the-board premium increase. Legislation that affected some types of insurance providers' costs more than others might have a much smaller impact if beneficiaries can switch from plans with larger premium increases to plans with smaller premium increases. Finally, a host of other factors—including, for example, the extent to which individuals value the results of the specific mandates and general economic conditions—will likely play a role in determining the impact that legislative mandates have on the number of insured individuals.

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Mr. Chairman, this concludes my prepared statement. I will be pleased to answer any questions.

Contact and Acknowlegement

For future contacts regarding this testimony, please contact William J. Scanlon at (202) 512-7114. Individuals making key contributions to this testimony included James C. Cosgrove and Susanne M. Seagrave.

(101859)

APPENDIX D - SUBMITTED FOR THE RECORD, RESPONSE OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC, TO QUESTION OF ROBERT ANDREWS, RANKING MEMBER, SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS, COMMITTEE ON EDUCATION AND THE WORKFORCE

INSERT TO THE RECORD--Testimony of Dan L. Crippen before the House Committee on Education and the Workforce, Subcommittee on Employer-Employee Relations, June 11, 1999

ANSWER TO MR. ANDREWS (page 25):

Unfortunately, we do not have adequate data to answer that question. We know that over the 1987-1995 period, the contributions that state and local government employers made for health insurance rose at an annual rate of 10.6 percent compared with 8.9 percent for private employers. (The most recent data available are for 1995.) But one cannot draw inferences about the effects of the ERISA preemption of health plan liability from those data. First, the data refer only to employers' contributions to premiums, not the entire premium, so growth rates are affected by changes in the share that employers pay. Second, the data are for aggregate premiums and reflect growth in the number of covered employees as well as growth in health insurance costs per employee. Third, other factors besides the ERISA preemption contribute to differential growth rates in premiums. For example, private employers moved more quickly from indemnity to managed care plans than state and local government employers did.

APPENDIX E - WRITTEN STATEMENT OF MIKE A. ANDERSON, 3M MANAGER OF TOTAL HEALTH, TOTAL COMPENSATION RESOURCE CENTER, ST. PAUL, MN ON BEHALF OF THE BUSINESS ROUNDTABLE

Statement by
Mr. Mike A. Anderson, 3M Manager of Total Health
Total Compensation Resource Center
on Behalf of The Business Roundtable

Before the Subcommittee on Employee/Employer Relations
of the
House Committee on Education and the Workforce

June 11, 1999

Statement by
Mr. Mike A. Anderson, 3M Manager of Total Health
Total Compensation Resource Center
on Behalf of The Business Roundtable

Before the Subcommittee on Employee/Employer Relations
of the
House Committee on Education and the Workforce

June 11, 1999

Good morning Mr. Chairman, Congressman Andrews, and other members of the House Employee/Employer Relations Subcommittee. My name is Mike Anderson and I am the Manager of Total Health for the 3M Company.

On behalf of The Business Roundtable (BRT), I am pleased to have this opportunity to discuss the health care experiences and challenges facing 3M and its ability to continue providing quality health benefits at a reasonable cost for its employees, dependents and retirees. Many of our experiences are similar to those of other large employers.

The BRT is an association of chief executive officers of leading U.S. corporations. The chief executives are dedicated to advocating public policies that foster vigorous economic growth, a dynamic global economy, and a well-trained and productive workforce.

The BRT's member companies employ approximately 10 million Americans. Our members serve as the primary source of health insurance coverage for most of these employees and their families – approximately 25 million Americans. All BRT companies have multistate operations. Sixty percent of our members operate in more than 40 states.

The ability to manage health care benefits and costs explain why BRT members have a significant interest in the issues under consideration by the subcommittee. As purchasers, managers and consumers of health care benefits and services, our members have gained a wealth of experience over the past decade in dealing with costs and quality – experience used to improve the accountability of health plans and health providers in furnishing high-quality health services to those 25 million Americans.

Like other BRT companies, 3M is committed to offering its employees a quality health benefits program. 3M employs over 73,000 employees worldwide with over 38,000 of them in the United States. 3M is one of the largest private employers in the state of Minnesota, where our corporate headquarters is located. As a purchaser of health care in the United States, however, we provide coverage for nearly 140,000 lives.

In my effort to provide information about 3M's health plan and how we manage our health care program and costs, this statement will address four broad themes:

1. 3M is proactive in the change of the health care system. In an effort to provide an overview of our plan, I will address in more detail the specifics of our plan and hope to illustrate how 3Mers have great flexibility in choice of doctors and access to appropriate treatment of their choosing.

2. Health care costs continue to be an area of concern. 3M has taken a very strategic approach to maximize health benefits while ensuring quality of care. Much of the success is based on 3M's philosophy, our purchasing efficiencies, and our program design and delivery.

3. The quality, value and costs of benefits and services delivered are continually evaluated. Resources available to provide health care benefits are limited; therefore, factors that drive up costs are carefully considered. These cost drivers must be considered when evaluating total compensation programs.

4. Principles underlying ERISA have provided a very successful framework for the creation of company-sponsored health benefit plans

for 3M, other multistate employers and their respective employees and families. Proposals to increase government involvement in private health care through new benefit mandates, weakening of ERISA preemption, or the creation of new bases for litigation are likely to undermine, rather than enhance, the quality of the health care delivery system and availability of employer-sponsored plans.

3M HEALTH CARE PLAN OVERVIEW

In order to understand the impact of cost factors to 3M, it is important to recognize the structure of our health benefit system. 3M company offers health care coverage (medical and dental plans) to its employees, retirees, family members and other groups such as those individuals on long term disability. In 1998, 3M had over 38,000 active employees in the United States and provided medical plan coverage for approximately 140,000 individuals, including retirees and family members.

3M's population is located throughout the United States. 3M facilities are located in 33 states, but employees and retirees reside in all 50 states. Headquartered in St. Paul, approximately 45 percent of the covered population reside in the state of Minnesota. However, key concentrations of individuals live in Southern California, Austin, Texas and various other small, medium and large communities. We have a significant number of plants located in small rural communities throughout the U.S., where the 3M plant is the largest employer and community benefactor.

3M offers multiple medical plans with a common design to 3Mers throughout the United States. The 3M common national plan design provides comprehensive coverage at affordable premiums. The plans are ERISA self-insured and are predominately administered under a Preferred Provider Organization (PPO) type of managed care arrangement. Self-insured companies bear the risks for benefit claims rather than an insurance company. PPO's comprise approximately 75 percent of 3M's active employee covered lives.

Other forms of managed care products are offered as an option in various communities such as the Minnesota Buyers Health Care Action Group

(BHCAG) plan and a limited number of Health Maintenance Organizations. 3M continues to provide managed indemnity plans to approximately 15 percent of the covered population in communities where it is appropriate. An indemnity plan is when an individual can seek health care services from any provider, and is reimbursed for the costs of those services without any benefit reimbursement differential.

The PPO's we have selected offer our employees choice of a large selection of providers for accessing care. With our PPO model, 3M broadly defines primary care to include a variety of providers such as General Practitioners, Pediatricians, OB-GYN, etc. We allow direct access, however, to any covered specialist without the need for administrative approval. Also, because we have an out of network provision in our plan design, 3Mers have access to all covered providers (at a 10 percent coinsurance differential).

In addition to medical plan coverage through PPO's, 3M provides a carved out prescription drug benefit administered through a Pharmacy Benefit Network. This network is structured similar to the PPO model allowing for broad access and out of network coverage. The prescription drug benefit provides access to FDA approved prescribed drugs in an open formulary.

3M's goal is to provide access to the best and most appropriate care available. We place very high value on the relationship and decisions made jointly between the patient and the medical professional. The patient and provider are usually in the best position to be making medical decisions based on that particular individual's circumstances. We also recognize, however, that large variations in the quality of care throughout the United States is a key national health care issue. Various published studies have identified key indicators of quality problems in the areas of, but not limited to: avoidable errors, overuse of services, underutilization of services and variation in services. Consequently, our general program is intended to facilitate delivery of the most effective nationally recognized guidelines for care.

WHY ARE HEALTH AND HEALTH CARE BENEFITS IMPORTANT TO 3M AND WHAT ARE OUR KEY SUPPORTING STRATEGIES?

The foundation for the programs and benefits we offer our employees are 3M's corporate values and human resource principles. This foundation is inherent in our overall health care benefits strategy. Our core health care benefits strategy recognizes and emphasizes the important relationship between health and productivity. Health related productivity not only impacts our company directly through employee absences due to an illness, but through other indirect means. Such an example is productivity losses due to employees dealing with ill family members or through our employees that are able to come to work, but are affected each day by a chronic/ongoing medical condition.

However, beyond the 3M productivity impact, we recognize a societal role we serve through our health care related activities in the communities we reside. This comes about in a variety of ways such as our interactions with the health care community, influence on the delivery system and influence on the health care market administrative entities. It is our goal to offer appropriate support for activities designed to improve the overall health of the population in communities we reside.

3M's efforts to help address an individual's complex health situation often bring forth providers, programs and resources from a variety of disciplines and organizations within and outside of 3M. As a result, health care benefits reside in 3M's "Total Compensation Resource Center" which has overall responsibility for Compensation and Employee Benefits and is specifically organized under a group identified as "Total Health." The "Total Health" organization where I work has responsibility for Health Care, Disability and Workers' Compensation activities. It is 3M's belief that health care is very intertwined with other company programs such as disability benefits, workplace health and safety activities, Employee Assistance, Wellness programs, Organizational Effectiveness improvement efforts and other related activities. This is partially due to our experience, which shows that other key factors, such as a person's psychological and social influences at home and at work, can have a significant influence on an individual's health.

WHAT HAS BEEN OUR METHODOLOGY AND EXPERIENCE IN MEASURING PERFORMANCE?

3M uses a variety of approaches to measure and evaluate our Human Resource services and assess employee needs. One broad measure is our employee satisfaction survey that monitors our employees' satisfaction, alignment with corporate goals, etc. In these surveys, 3Mers score high in overall satisfaction and score consistently high regarding satisfaction with the company's health care benefits program.

Specifically in the area of employee benefits, other measures such as evaluations of service quality are utilized to monitor performance and identify improvement opportunities. Also, overall cost performance measures are used to monitor the costs of delivering benefits programs. In the area of Health Care, measurements utilize health and productivity; direct and indirect components in monitoring cost and performance. Specifically, Health Care, Disability, Workers' Compensation, and Employee Satisfaction information are linked together to assess results and improvement opportunities. 3M has begun a process which will lead to the sharing of aggregate Health and Productivity measurements with 3M business units for purposes of monitoring and improving health and productivity results at a local level.

3M's cost experience over the past two decades has paralleled the direction of other large employers. In the late 1980's and into early 1990's, 3M experienced double digit inflation. However, after a strategic plan in the area of health care was drafted in 1993 and implementation activities commenced in 1994, 3M health care costs have been maintained at a rate of approximately 2 percent per year (a further description of the strategic plan follows in the next section). Other employers in Minnesota participating in the BHCAG have experienced an overall average trend of less than 2 percent over the past five years in the BHCAG plan. The two percent includes a negative 11 percent in the year the plan was introduced. We will also note however, that 3M's most recent overall national experience suggests an increase in trend at 10 to 14 percent average, which we are currently assessing. 3M's experience is unlike a lot of large

employers. Many large companies are experiencing premium increase in some markets of up to 20 percent.

At this time, I would like to provide a couple of comments about the structure and key components of our health care costs. First, our ability to offer national plans provides us the opportunity to focus more of our expenditures on the delivery of health care. This is due primarily to our ability to design, deliver and manage programs and costs at a national level through the ERISA framework. 3M's national plan design, PPOs and national administrative services are key vehicles to achieve these results. For example, because of our national approach, 3M has been able to maintain our administrative expenditures at approximately 7 percent of overall health care expense. With these positive results, we have been able to finance continuous improvements to the plan for 3Mers. Improvements in the area of preventive care coverage at 100 percent, mental health coverage and other features have been incorporated into our plan over recent years as a result of our plan savings.

Second, while 3Mers receive the same level of benefits, the actual cost to 3M varies by region due to a number of factors such as variation in care delivery practices, pricing differences and supply/demand issues in various markets. For example:

In the following region:	**Annual average health care costs per Enrolled employee**
Midwest	Range from $4000 to $4600
West and Southwest	Are approximately $6200
Northeast	Range from $5200 to $8000
South Central	Are approximately $5000

An important aspect of our Total Compensation principles provides that salaried 3M employees are paid using national pay scales and receive common national benefits such as health care. Consequently, if 3M were to discontinue providing health care benefits to 3Mers, we would face difficult employee relations issues from those 3Mers seeking to purchase health care coverage on their own in communities with high health care costs. For example, if 3M employees were forced into individual markets, 3M would most likely be inclined to provide no more than the national average of 3M's overall health care expense such as $5000. Because the

cost of health care in some parts of the country exceeds $5000, this could also result in additional uninsured individuals.

3M'S RESPONSE TO COST AND QUALITY CONCERNS

As previously described, the high cost period that began in the late 1980's was a wake-up call for 3M and many other employers. 3M's response was to establish a cross-functional team chartered to establish a five-year strategy in the area of health care benefits. The strategy encompasses such key areas as care management, population/individual health management, quality and measurements, and plan design/delivery.

The following describes those four key areas of our strategy. First, "care management," which commenced in 1994, included our approach to contracting with providers through PPOs, expansion of our Employee Assistance Program, establishing a care counseling line, and joining the BHCAG coalition in the Twin Cities. Our overall direction is to establish partnerships with key provider organizations. In the Twin Cities area for example, close interactions through Quality Councils established with large provider groups and key activities with the "care systems" participating in the BHCAG has yielded positive steps toward improving care for 3Mers and others in the community.

Second, "population/individual health management" includes establishing a variety of resources, programs and philosophies designed to allow 3Mers to assess health related needs, follow appropriate prevention and early detection strategies and better manage existing health conditions. Specific programs such as smoking cessation, pre-natal care and 100 percent coverage in the medical plan for appropriate preventive care services are included in this area. In addition, a variety of resources have been established through the care counseling line, intra-net site, and various other resources for 3Mers to access regarding their health needs.

Third, "quality and measurement" activities have been a key focus of our strategy. It is our belief that quality, measurements and establishing appropriate accountabilities is the long-term solution to managing health care. Our strategies are twofold. First, we are committed to identify and engage in measurement and quality activities targeted at 3Mers, providers

in 3M communities and others (some of these activities have been previously described). Our second strategy is to become involved (where appropriate) with national, regional and community organizations and initiatives in the area of quality and measurements. For example, 3M has involvement in the Midwest Business Group on Health, Washington Business Group on Health and the Minnesota Health Data Institute.

Finally, in the area of "plan design and delivery," 3M has established a plan design framework that provides appropriate cost sharing along with a structured approach that offers reasonable flexibility in order to provide appropriate coverage and financial protection for 3Mers. We continuously monitor all aspects of our national plan design, to ensure it meets our strategic direction and provides value for 3M and its 140,000 covered lives.

Our overall direction is to bring together the four strategic areas identified above under a long-term approach for 3M and its employees. In other words, we recognize that while the health care industry is dynamic in nature, our goal is to maintain our strategic direction that we believe will allow us to sustain a competitive, value-added benefits offering for our employees.

WHAT DO WE EXPECT THE FUTURE TO BRING IN HEALTH CARE AND HOW WILL 3M RESPOND?

First, it appears health care inflation has recently made a return appearance in the industry, which will likely bring about a number of activities by various constituents around the country. It is our belief that there continue to be underlying, fundamental issues within the industry that should serve as the source of opportunity for improvement. Some of the primary issues include the areas of:

- Quality concerns
- Consumer behavior regarding: lifestyle, prevention/early detection, demand for the newest treatment, and compliance with treatment plans
- Cost shifting
- Lack of provider accountability in the system
- Aging population

- Consolidation in the industry
- Improving provider and patient communications

Since a discussion of all these issues is not practical at this time, a particular area of concern to be briefly highlighted is quality in the industry. In a 1998 Advisory Commission on Consumer Protection and Quality in the Health Care Industry report entitled "Quality First: Better Health Care for All Americans," an assessment and series of recommendations toward improving quality in the industry was provided. This is a very positive step toward improvement and we believe appropriate activity involving all key stakeholders is necessary to continue to get at this very critical issue.

3M's ongoing strategy regarding the major health care issues will be to continue focusing on partnerships with providers, to remain a return to work accommodating employer, and to engage our employees, retirees and family members in activities designed to improve their health and become better health care consumers.

3M's long term ability to provide competitive health care benefits to our employees is contingent upon a number of factors. It is our intent to continue to offer such programs because of the relationship to our core values and Human Resource principles. However, changes in the health care system or legislation that results in significantly higher costs, could ultimately result in benefit plan reductions or plan elimination for 3Mers.

ERISA AND 3M'S EXPERIENCE IN MINNESOTA

The Employee Retirement Income Security Act of 1974 was enacted to encourage the creation of comprehensive employer-sponsored pension and welfare programs. It established a uniform regulatory framework to ensure fair dealing in the administration of such plans. Through preemption of conflicting state laws and the creation of exclusive federal administrative and judicial remedies, the Act has provided a uniform, yet highly flexible structure within which multistate employers and their employees have been able to develop self-insured benefit plans which satisfy their mutual needs.

ERISA has provided the umbrella under which 3M has been able to develop as a sophisticated purchaser. 3M operates consistently from state to state, arranging for cross-state service delivery, and negotiating directly with providers and networks without having to gain approval from state regulatory bodies to meet state-imposed requirements.

Cost savings for 3M and its employees is another benefit of operating as an ERISA plan. In analyzing a single plan that provides benefits for 3M and other Minnesota companies, the BHCAG reported that significant savings were created in 1993 when its member employers went from more expensive state-regulated insured HMOs to self-insured status under the protection of ERISA. These savings were passed directly on to employees in the form of lower premiums and higher wages.

Since 1993, the cost increases incurred by employers under the protection of ERISA have been less than those employers in Minnesota who cannot self-insure and have to buy coverage through state-regulated insurance companies.

According to BHCAG's findings, its members' costs have increased in recent years due to significantly higher pharmacy costs and a substantially increased illness burden for employees and their families. Their two-year trend in 1997 and 1998 was 6 percent per year after adjusting for the increased illness burden of the population. Without that adjustment, their average annual increase during those two years was 10 percent.

In spite of these recent increases, we are still keeping the cost of insurance for our employees down because of ERISA. Minnesota businesses that buy insurance from state regulated health plans are experiencing increases averaging around 15 percent per year or more.

If we lose our ERISA protection, we would likely lose our ability to manage costs and influence the quality in key markets. For example, in Minnesota, three health plans control 85 percent of our market. Changes in ERISA would likely eliminate some of the successful alternatives to traditional insurance mechanisms. The result would likely be increased costs, higher premiums and reduced employee choice.

CONCLUSION

In conclusion, 3M has actively managed its total health benefits through collaboration with the provider community, other employers and other stakeholders. This approach has provided affordable, accessible, high quality appropriate care.

Our strategic approach to health and productivity has resulted in high employee satisfaction, a better integration of all health related services, improved employee consumerism and programs designed to improve health.

Employers are in the unique position to engage employees in the complex inter-related areas of health, productivity and Human Resource related activities. Thus, we are in an excellent position to measure the performance of benefits and health-related services delivered. We are also in a position to inform and educate employees to become better health care consumers.

The ERISA framework has allowed us to develop and deliver high quality and cost effective health plans to our nationwide employee population. The re-appearance of recently rising costs makes it imperative that we retain the key tools we possess today to allow us to identify and address opportunities to improve the quality and cost of health care.

APPENDIX F - WRITTEN STATEMENT OF TRACY CASSIDY, PRINCIPAL, WILLIAM M. MERCER, INCORPORATED, WASHINGTON, DC

WILLIAM M. MERCER

TESTIMONY OF TRACY CASSIDY
WILLIAM M. MERCER, INCORPORATED
BEFORE
THE SUBCOMMITTEE ON EMPLOYER-EMPLOYEE RELATIONS
OF THE
HOUSE COMMITTEE ON EDUCATION AND THE WORKFORCE

"THE RELATIONSHIP BETWEEN HEALTH CARE COSTS AND AMERICA'S UNINSURED"

JUNE 11, 1999

I want to thank the committee for the opportunity to appear this morning. For the past twelve years I have been with William M. Mercer and worked as a consultant to large employers on the design and management of the health care benefits provided to employees. Today I will share data with you from:

- Mercer's "National Survey of Employer Sponsored Health Plans" on health insurance cost trends, and
- Employee Benefit Research Institute (EBRI) Issue Brief findings on "Sources of Health Insurance and Characteristics of the Uninsured."

Trends in employer sponsored health plan costs

- Total health plan costs for active and retired employees rose 6.1 percent in 1998. This is the highest rate of increase since 1993. Health benefit costs far outpaced the medical component of the Consumer Price Index, which grew 3.4 percent in 1998.
- Health care costs are projected to increase approximately 9% in 1999.
- Migration out of traditional indemnity plans slowed to a trickle in 1998. Following years of sharp decreases, enrollment in traditional plans eroded only 2 percentage points in 1998, from 15 to 13 percent.
- Employee enrollment in more restrictive forms of managed care, HMOs and point-of-service plans, fell slightly in 1998, from 50 percent of all covered employees in 1997 to 46 percent. Enrollment in PPOs rose from 35 to 40 percent.
- A big increase in prescription drug costs helped fuel the overall cost increase. Employers reported an average increase in drug cost of 13.8 percent at their last renewal.

The Uninsured

- The percentage of nonelderly uninsured Americans has been increasing since 1987 (14.8% uninsured in 1987 compared to 18.3% uninsured in 1997). However, the portion of Americans covered by employment-based health insurance increased between 1993 (63.5%) and 1997 (64.2%).

- Two findings from a comparison of workers ages 18-64 with employment-based health insurance, with Medicaid, and without health insurance from 1987 to 1997:

  1. There was an increase in the uninsured from 1987 to 1990 (from 14.6% to 17.8%) at the same time employers were experiencing double digit increases in annual health insurance costs. In 1991, the annual rate of increase in health care costs dropped (from 17% to 13%) as did the percentage of uninsured (from 17.8% in 1990 to 16.8% in 1991).

  2. The increase in the percentage of uninsured from 1996 to 1997 appears to be more closely aligned with a change in the percentage of Americans covered by Medicaid. From 1996 to 1997, the percentage of Americans with Medicaid decreased from 4.2% to 3.6% while the percentage of the uninsured population increased from 17.5% to 18.2%. For the same period, the change in percentage of workers with employment-based insurance shifted only slightly from 72.3% to 72.2%.

- While there does appear to be a link between the increase in employer health care costs and the increase in the uninsured population from 1987 to 1990, the most recent increase in the number of uninsured appears to be aligned with a decline in those covered by Medicaid.

- The cost increases of employer sponsored health benefits projected for the year 2000 and beyond could have an impact on the future number of uninsured.

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The Relationship between Health Care Costs and America's Uninsured

Tracy Cassidy
William M. Mercer, Incorporated

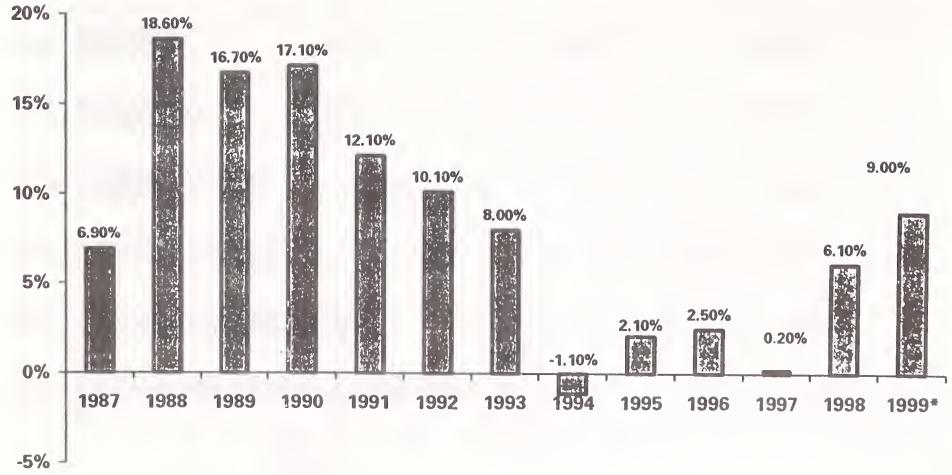
Subcommittee on Employer-Employee Relations House of the Committee on Education and the Workforce
June 11, 1999

WILLIAM M. MERCER

Mercer/Foster Higgins National Survey of Employer-Sponsored Health Plans

- ▲ Established 1986
- ▲ Since 1993, conducted using a national stratified random sample
- ▲ Results can be projected for all U.S. employers with 10 or more employees
- ▲ 4,181 respondents in 1998
- ▲ Largest, most comprehensive survey on the topic

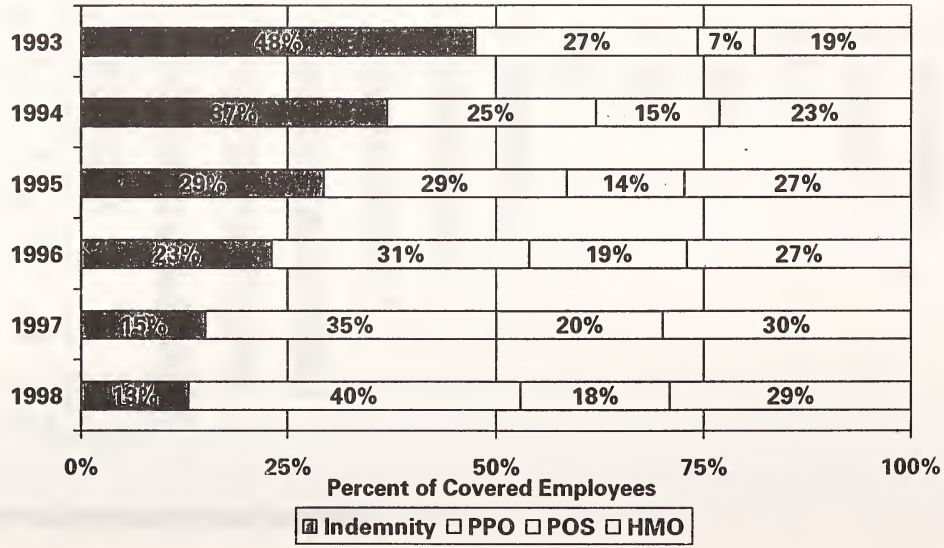
First Major Cost Increase in Five Years



* Average expected increase of 72% of respondents

WILLIAM M. MERCER

First Ever Decline in HMO/POS Enrollment



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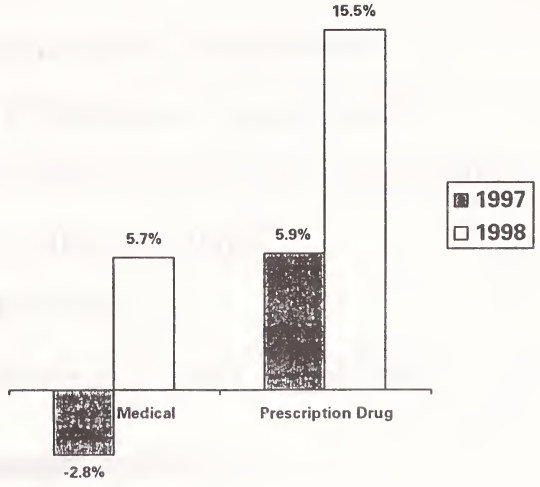
Prescription Drug Costs - Trend

(Large Employers +500)



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Prescription Drug Costs

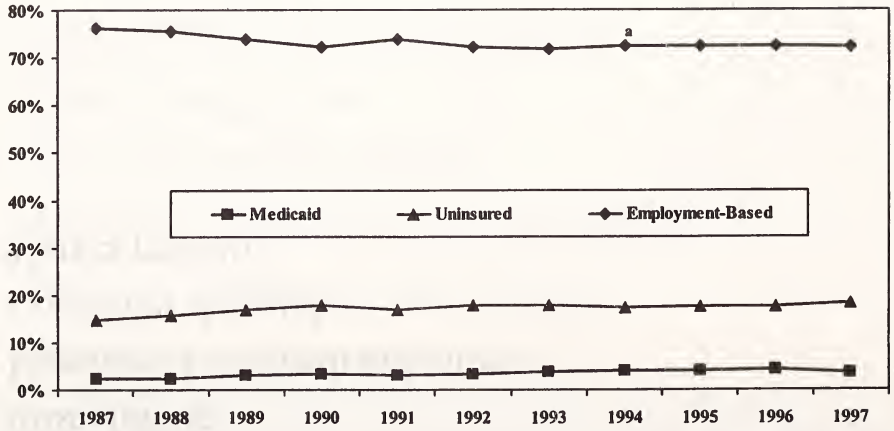
Factors influencing cost increases

- ▲ higher drug prices
- ▲ new prescription drugs
- ▲ increased prescribing by physicians
- ▲ direct to consumer advertising
- ▲ prescription drug card plans

Other factors influencing trend...

- ▲ Cost shifting
- ▲ Mandated benefits/legislation
- ▲ Consumer demand
- ▲ Market pressure

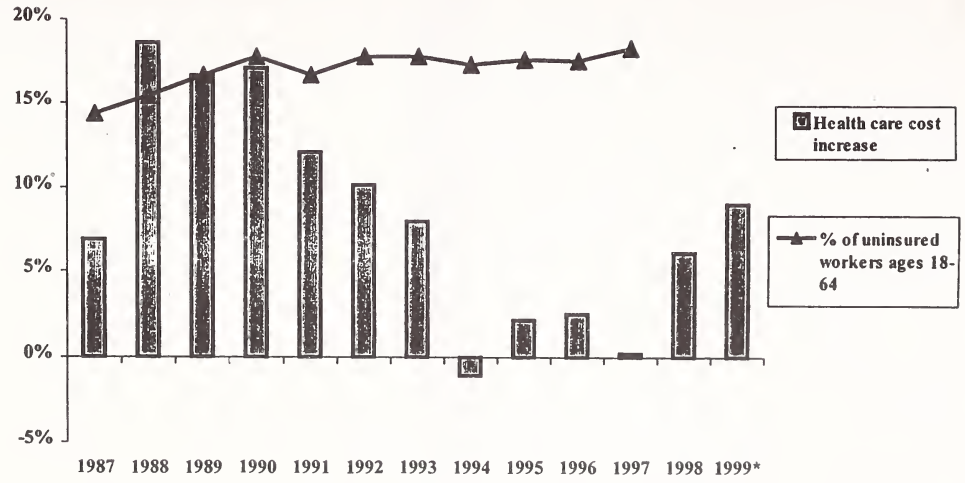
Percentage of Workers, Ages 18-64, With Employment-Based Health Benefits, Medicaid, and Without Health Insurance,[a] 1987-1998



Source: Employee Benefit Research Institute analysis of the March 1988-1998 Current Population Surveys (CPS).
[a]Medicaid and uninsured data are not completely consistent with data from previous years. Starting with the March 1998 Current Population Survey, the Bureau of Census modified its definition of the population with Medicaid and the population with Medicaid and the population without health insurance coverage. Previously, individuals covered solely by the Indian Health Service were counted in the Medicaid population. Beginning with data from the March 1998 CPS, individuals covered solely by the Indian Health Service are counted as uninsured. This change decreased the Medicaid population and increased the uninsured population by 300,000, or 0.2 percent

WILLIAM M. MERCER

Uninsured vs. Annual Cost Increase



* Average expected increase of 72% of respondents

WILLIAM M. MERCER

APPENDIX G - WRITTEN STATEMENT OF DEBORAH J. CHOLLET, Ph.D, VICE PRESIDENT, ALPHA CENTER, WASHINGTON, DC

Health Insurance Costs and Coverage:
Lessons and Future Directions

Testimony of
Deborah J. Chollet, Ph.D.
Vice President
Alpha Center

Submitted to

The Subcommittee on Employer-Employee Relations
Committee on Education and the Workforce
U.S. House of Representatives

Hearing on
The Relationship Between Health Care Costs and America's Uninsured

June 11, 1999

This statement reflects the views of the author only,
and should not be attributed to Alpha Center, its board or its sponsors.

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Health Insurance Costs and Coverage:
Lessons and Future Directions

Testimony of
Deborah J. Chollet, Ph.D.
Vice President
Alpha Center
Washington, DC

During the last several decades, health care costs in the U.S. have risen inexorably. At the same time, reported rates of private insurance coverage – and coverage from employer plans, in particular – has declined. These two trends undoubtedly are related.

While rising health care costs alone would be expected to reduce the amount of health insurance purchased in a voluntary system, cost growth has coincided with at least two other factors that also discourage employers from offering and paying for health insurance benefits: the stagnation of wage growth among low-wage workers and a gradual shifting of employment to smaller firm sizes, where the administrative cost of group insurance is much greater than in very large firms.

Health care costs have continued to grow.

Since 1990, health care costs in the US have risen more slowly than in the preceding decade. Nevertheless, health care costs have continued to rise significantly, both absolutely and relative to growth in other sectors of the economy. Since 1993, personal health care spending has risen at average annual rate of about 5 percent. Extrapolating from past rates of growth, HCFA projects that annual health care cost growth will rise to 6.5 percent between 1998 and 2001, and to 7.5 percent between 2002 and 2007 (Smith et al., 1998). While other projections of health care cost increases are somewhat lower (Ginsburg, 1999), most analysts expect that nearly all of the projected growth in health care spending over the near term will be concentrated in the private sector rather than in government programs such as Medicare.

Expenditures for each of the major components of personal health care for the nonelderly population – hospital care, physician services, and prescription drugs – have grown over the last decade (Figure 1). However, the expenditures for prescription drugs have grown most rapidly, driving the growth in total health care costs and especially the cost of private insurance plans. Between 1995 and 1996 (the most recent year for which HCFA has produced expenditure estimates by component), personal health care spending for prescription drugs grew nearly 8 percent, nearly 3 times as fast as the 3-percent growth in spending for hospital and physician services over the same period.

Health insurances prices are rising.

While the underlying cost of health care is an important factor in rising health insurance costs, other factors also affect the price of private health insurance. In recent history, possibly most

important has been the transition of health insurance coverage to managed care. By constraining the use of expensive hospital care and negotiating to reduce the prices paid to health care providers, these plans have driven declining growth in expenditures for hospital and physician services. In 1995, nearly three-quarters of insured workers were enrolled in some variety of managed care plan (Levit et al., 1998). Workers in large firms historically have constituted most of the enrollment in managed care, but since 1993 workers in smaller firms have constituted much of the growth in managed care enrollment.

While managed care enrollment may yet continue to grow, its growth is certain to be more moderate than in the past. Moreover, managed care is unlikely to generate the "savings" in health care costs that it has in the past, simply because these plans have already driven down provider margins in highly penetrated markets. Consequently, the factors likely to drive the cost of health insurance for employers, especially in the near term, will relate to the dynamics of the insurance market itself.

Over the next few years, the insurance industry's "underwriting cycle" is likely to be among the most important factors driving growth in insurance prices. The underwriting cycle is the fall in insurance prices that occurs when insurers compete aggressively for market share, followed by an increase in prices as insurers attempt to recover lost profits. While commercial insurance underwriting cycles historically have been relatively short (about three years), the aggressive growth of managed care apparently has lengthened the underwriting cycle to as long as eight years.

Observing the relatively high ratios of medical costs to premiums (called loss ratios) that many insurers have reported in recent years, most analysts believe that an upswing in the underwriting cycle explains much of the large increases in insurance premiums that employers have reported in the last year. By definition, the underwriting cycle is a temporary phenomenon. However, the concentration of the insurance industry within states and across state lines, and the conversion of some large plans – especially Blue Cross and Blue Shield plans – to for-profit, may produce a longer upward cycle in insurance prices than has occurred historically.

Employer coverage is declining, and the problem of the uninsured is growing.

For more than a decade, employer-based coverage among workers and their families has gradually declined, driving growth in the number and percentage of Americans who are uninsured (Table 1). This decline has occurred among workers of all types, and in all industries, firm sizes and areas of the country (Monheit, 1994; Acs, 1995; Long and Rodgers, 1995). In recent years, employer coverage has recovered somewhat, as record-high rates of employment have begun to increase employee wages and apparently also the ability of both employers and employees to afford health insurance benefits.

Nevertheless, the number of Americans without health insurance continues to rise by approximately 1 million people per year, reaching 43 million -- more than 18 percent of the population under age 65 – in 1997. Nearly all of the uninsured are in families of workers.

Coverage for low-wage workers is the problem.

One of the most striking aspects of employer-based health insurance coverage over the past has been the increase in the contributions that employers require from their workers to cover either themselves or their dependents in group plans. While the proportion of workers with access to employer-sponsored health insurance benefits was stable between 1987 and 1996 (at 82 percent), their family-wide "take-up" rate (the worker's own take-up rate adjusted for access to dependents coverage from another worker in the family) declined from 93 percent to 89 percent (Cooper et al., 1997). Nearly all of this decline occurred among workers earning less than $10 per hour, while take-up rates among high-wage workers remained high (93 percent).[1]

The increase in workers unable to afford employee contributions even when offered coverage from an employer plan coincides with the stagnation of earnings in low-wage jobs. The growing disparity between low and high wages during the last decade has been attributable entirely to the stagnation or decline of earnings among workers in low-wage jobs, while the earnings of high-wage workers have grown rapidly (Bernstein and Mishel, 1997). As a result, family income at low levels also has stagnated. Average household income in the poorest one-fifth of US households increased by only 0.1 percent between 1984 and 1994, while the top one-fifth of households saw their average income jump by 20 percent (Kacapyr, 1996). Between 1996 and 1997, average income among families in the bottom fifth of the income distribution rose just 0.9 percent (by $80), while average income in the middle fifth rose 2.4 percent ($880) and income in the top fifth rose by 3.9 percent ($4,600) (Center on Budget and Policy Priorities, 1998).

In 1997, 17 percent of the population lived in families of workers who earned less than $20,000 per year (approximately $10 per hour for a full-time full-year worker). Families of low-wage workers account for 54 percent of the uninsured population (Figure 2).

While the proportion of workers in small firms has actually declined (from 30 percent in 1990 to 24 percent in 1997), employees in small firms are still much less likely to be offered health insurance benefits than workers in larger firms, and the cost of small-group insurance remains higher for the same level of benefits. Historically, much of the difference between the cost of large-group coverage and small-group coverage per worker relates to much higher average administrative and marketing costs for small groups. Small groups also have been slower to move into managed care plans, so that they have been less likely to participate in the slower medical cost growth that managed care has produced. As a result, while 24 percent of workers are employed in firms with fewer than 25 workers, these workers represent nearly one-half of uninsured workers (48 percent).

While the cost of health insurance is greater in small firms for the same level of benefits, low-wage workers much are more likely to be employed in these firms than are high-wage workers.

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[1]For workers earning less than $7 per hour, the average family take-up rate declined from 89 percent to 76 percent between 1987 and 1996; for workers earning $7-$10 per hour, the average family take-up rate declined from 94 percent to 86 percent (Cooper et al., 1997).

In 1997, 30 percent of low-wage workers earning less than $20,000 per year were in firms with less than 25 employees, and 21 percent were in firms of less than 10 (Figure 3). In contrast, only 12 percent of workers earning more than $30,000 were in firms with fewer than 25 employees, and only 6 percent were in firms with fewer than 10. Low-wage workers are much less likely than their high-wage counterparts to have health insurance from an employer plan, but especially less likely when they are employed in small firms (Figure 4).

Lessons and future directions

During the last two decades, various states and local areas have attempted a number of experiments designed to increase employer coverage, especially in small firms. These have included low-cost health insurance plans which achieved low cost either because they were subsidized (usually via negotiated discounts from participating providers) or because their benefit design was meager (generically referred to as "bare bones"). Some jurisdictions (for example, Oregon) offered tax credits to small employers that newly offered health insurance benefits. These experiments generated a number of lessons, but two are perhaps the most important: (1) experimental programs, because they are temporary, are unappealing to employers and perhaps also to their workers; and (2) in order to make significant gains in employer-based health insurance coverage, very significant subsidies are required – so that the net cost to low-wage workers is negligible (Helms et al., 1992).

Over the last decade, the states have turned to small-group insurance reform in an effort to make health insurance coverage more accessible to firms that have workers with health problems or that hire older workers. These reforms included guaranteed issue and renewal provisions for small groups, as well as portability requirements for workers changing plans and, less commonly, rate restrictions intended to increase cross-subsidies toward workers and firms with workers likely to have greater health care needs. In 1996, the Health Insurance Portability and Accountability Act (HIPAA) codified some of these provisions in Federal law, and spurred states that had not enacted minimum standards – guaranteed issue, guaranteed renewal and modest restrictions on preexisting condition exclusions – to do so. Preliminary evidence suggests that the success of these reforms in improving coverage rates among older workers and workers with health problems has come at the expense of slightly lower coverage among younger, healthy workers (Simon, 1999). This relationship would suggest that group health insurance has become more expensive as it has driven out some lower-risk workers, probably further eroding the ability of low-wage workers to afford coverage.

Other efforts to make health insurance more affordable to small firms have also had minimal effects. These have included establishing purchasing cooperatives for small groups, which seem to appeal to small groups seeking choice among managed care plans but not to have affected the cost of coverage in any significant way (Wicks and Meyer, 1999; Lawlor, 1999). In an early analysis of these organizations, Mark Pauly (1993) noted:

> "[t]he higher per-employee administrative cost in a set of ten, 25-employee firms, as compared to a single group of 250, arises because

> each firm must be sold insurance, each firm must receive a premium bill, and each firm must be serviced... But, combining the ten firms into one HIPC does not change the number of sales, bills or services required; you cannot make a giant just by rounding up a passel of midgets."

Thus, any significant savings to be gained by establishing small-employer purchasing cooperatives that can deny entry (such as association plans) are more easily gained by selecting low-cost risks into the cooperatives' plans than by reducing the cost of these plans by negotiating reduced margins for health care providers or insurers.

The lessons to be learned from these efforts are important. Employees (and their employers) want "standard" health insurance benefits that offer good coverage for most health care services. They are willing to accept constraints on choice, but prefer some choice to none. They are likely to choose health insurance plans based on price (and sometimes also access to a known health care provider), and they presume a high standard of health care quality. Finally, if they are low-income, they require a significant subsidy to afford health insurance, given the cost of health insurance relative to their incomes and the competing demands on their modest resources.

Many states have begun to consider reforms targeted to these lessons. These include patient protection to alleviate discrepancies in quality that consumers cannot predict in choosing among health plans. But, with regard to access among low-wage workers and their families, they also include permanent subsidized health insurance programs (in Minnesota and Washington) and programs that help low-wage workers buy into employer coverage when it is offered (in Oregon and Illinois). Others are considering options for helping parents buy into the same coverage that their children receive via their Federally subsidized children's health insurance program (CHIP) and ways to use their limited Title 1931 option to extend Medicaid eligibility to low-income workers.

While many states continue to look for ways to assist low-income workers to afford health insurance coverage, many analysts are again turning to the Federal tax code as the most promising – and sweeping – option for assisting them. The current tax treatment of employer-provided health benefits is by any standard highly inequitable, providing a subsidy to high-income workers that is lower or entirely unavailable to low-income workers. Federal attention to redistributing tax subsidies for health insurance is likely to be the broadest avenue to resolving the nation's long-standing and growing problem of access to health insurance. Most feasible alternatives to further constrain health care costs are unlikely to affect this problem significantly.

References

Acs, Gregory (Spring 1995). "Explaining Trends in Health Insurance Coverage Between 1988 and 1991," *Inquiry* 32(1): 102-110.

Bernstein, Jared and Lawrence Mishel (December 1997). "Has Wage Inequality Stopped Growing?" *Monthly Labor Review* 120: 3-16.

Center on Budget and Policy Priorities (October 8, 1998). "Poverty Rates Fall, but Remain High for a Period with Such Low Unemployment." http://www.cbpp.org/9-24-98pov.htm.

Cooper, Philip F. and Barbara S. Schone (Nov/Dec 1977). "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987 and 1996." *Health Affairs* 16: 142-149.

Ginsburg, Paul B. (Jan/Feb 1999). "Health Spending: Questioning the Assumptions." *Health Affairs* 18: 272-273.

Helms, W. David, Anne K. Gauthier and Daniel J. Campion (Summer 1992). "Mending the Flaws in the Small Group Market." *Health Affairs* 11: 8-27.

Kacapyr, Elia (October 1996). "Are You Middle Class?" *American Demographics*. http://www.demographics.com/Publications/AD/96_AD/9610A31.html.

Lawlor, Janice S. (February 1999). "An Evaluation of Caroliance: North Carolina's Voluntary Health Insurance Purchasing Alliance Program for Small Employers" (unpublished). http:www.phs.wfubmc.edu/insure/Carolianz.html.

Long, Stephen H. and Jack Rodgers (Spring 1995). "Do Shifts Toward Service Industries, Part-time Work and Self-Employment Explain the Rising Uninsured Rates?" *Inquiry* 32(1): 111-116.

Levit, Katherine R., Helen C. Lazenby and Bradley R. Braden (Jan/Feb 1998). "National Health Spending Trends in 1996." *Health Affairs* 17: 35-51.

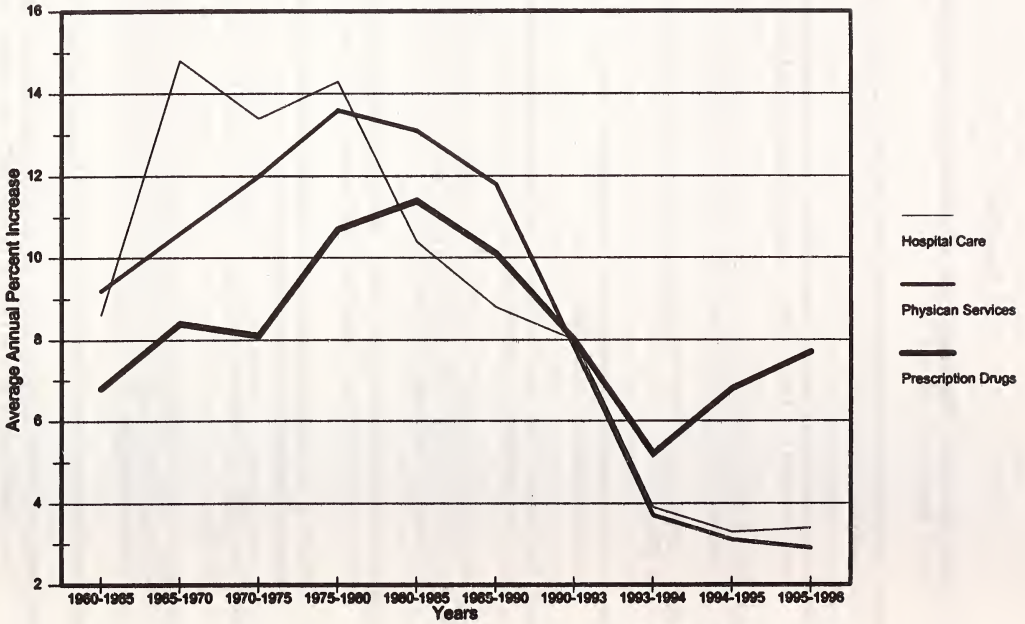
Monheit, Alan (1994). "Underinsured Americans: A Review," *Annual Review of Public Health* 15: 461-485.

Pauly, Mark V. (1993). "Killing with Kindness: Why Some Forms of Managed Competition Might Needlessly Stifle Managed Care," in R.B. Helms, ed, *Health Policy Reform: Competition and Controls* (Washington, DC: AEI Press).

Simon, Kasali Ilayperuma (1999). "Did Small Group Health Insurance Reforms Work?" (unpublished).

Smith, Sheila, Mark Freeland, Stephen Heffler, and David McKusick (Sept/Oct 1998). "The Next Ten Years of Health Spending: What Does the Future Hold?" *Health Affairs* 17: 128-146.

Figure 1: Percent Increases in Selected Components of Health Care Expenditure, 1960-1996



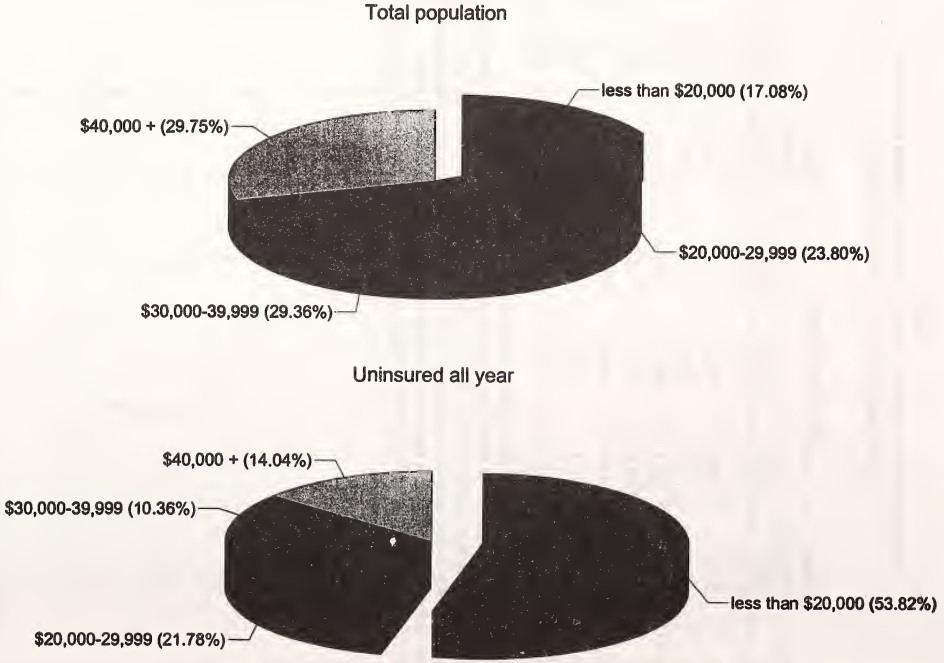
Source: Alpha Center Tabulations of HCFA Data

Table 1
Percent of the Population Under Age 65 with Health Insurance, by Selected Source of Coverage: 1990-1997

Calendar year	Private coverage, total	Employer coverage			Other private coverage	Medicaid	Uninsured
		Total	Direct	Dependent			
1990	73.3%	64.7%	32.6%	32.2%	8.6%	10.0%	16.6%
1991	72.3	64.0	32.2	31.8	8.2	11.0	16.7
1992[a]	70.4	61.9	30.8	31.1	8.5	11.8	17.8
1993	69.7	60.8	31.8	29.0	9.2	12.8	18.1
1994	71.1	64.8	32.9	31.9	6.3	12.6	17.3
1995	71.0	65.0	32.9	32.1	6.0	12.6	17.5
1996	71.1	65.1	33.0	32.1	6.0	12.1	17.8
1997	71.1	66.7	34.9	31.7	6.7	10.4	18.1

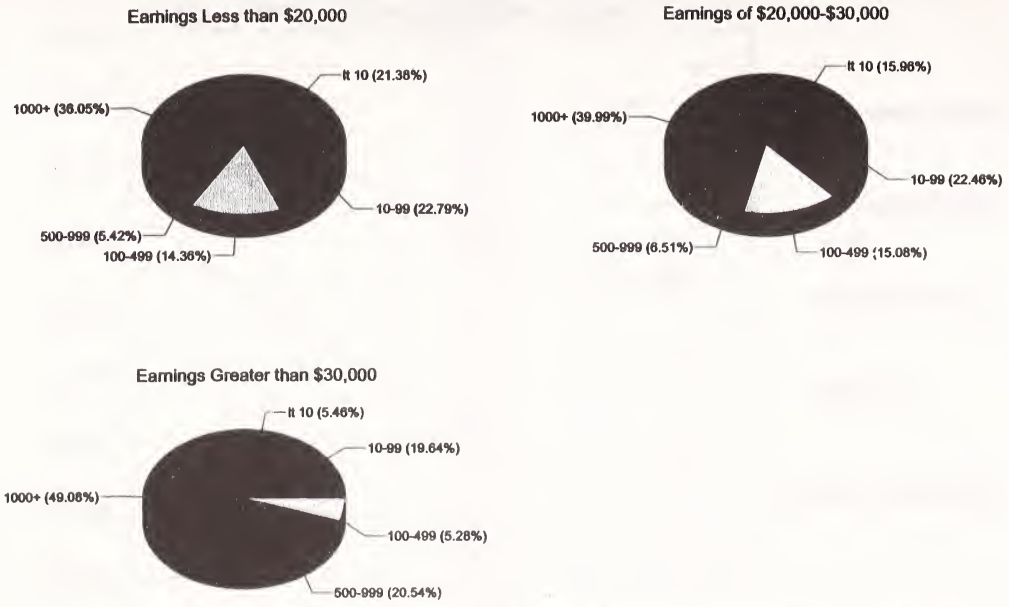
Source: Alpha Center tabulations of the March Current Population Surveys, 1991-1998.
Note: Estimates exclude members of the military and their families. Tabulations for 1994-1997 may differ from published data from the Bureau of the Census and elsewhere, as children who report health insurance as a dependent of someone not living in the household are assumed to have coverage from an employer-based plan. This assumption conforms with definitions (and Census Bureau practice) for all years prior to 1994.
[a] 1992-1996 figures are based on 1990 population weights and do not directly compare to earlier years.

Figure 2: Total Pop. and Uninsured in Worker Families by Family Head Earnings, 1997



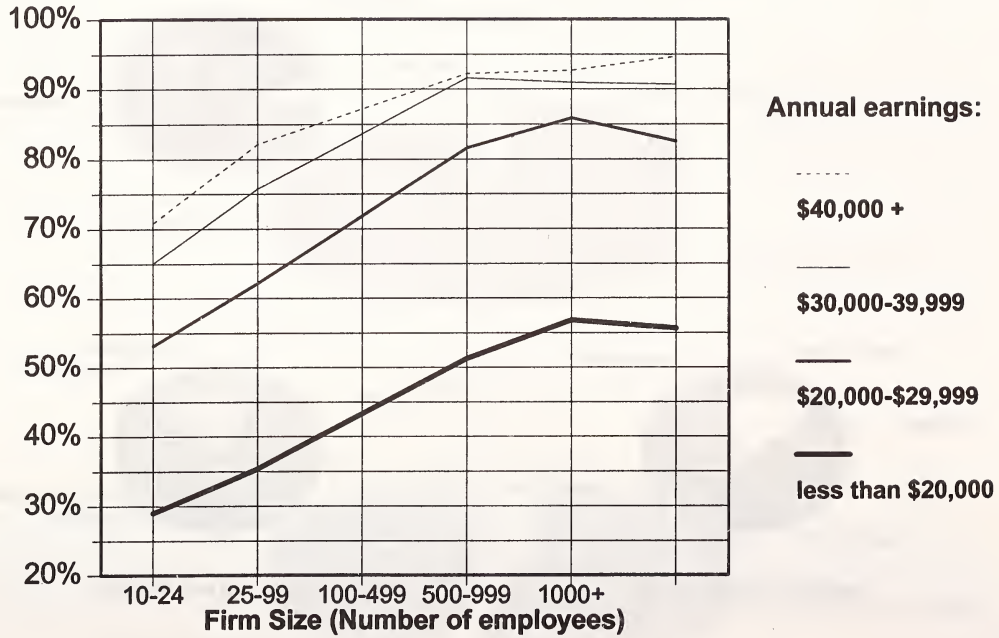
Source: Alpha Center tabulations of the March 1998 Current Population Survey (US Bureau of the Census).

Figure 3: Distribution of Workers by Firm Size and Family Head Earnings, 1997



Source: Alpha Center tabulations of 1998 Current Population Survey, US Census Bureau

Figure 4: Pct. of Workers with Employer Health Coverage by Wage and Firm Size, 1997



Source: Alpha Center tabulations of the March 1998 Current Population Survey (US Bureau of the Census).

APPENDIX H - WRITTEN STATEMENT OF CHARLES N. KAHN, III, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA, WASHINGTON, DC

Health Insurance Association of America

Statement of

CHARLES N. KAHN III

President

HEALTH INSURANCE ASSOCIATION OF AMERICA

Before the

EMPLOYER/EMPLOYEE RELATIONS SUBCOMMITTEE

Of The

COMMITTEE ON EDUCATION AND WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

The Relationship Between Health Care Costs and America's Uninsured

June 11, 1999

555 13th Street, NW - Suite 600 East, Washington, D.C. 20004-1109 202/824-1600

Introduction

Chairman Boehner, Representative Andrews, and members of the Subcommittee, I am Charles N. Kahn III, President of the Health Insurance Association of America (HIAA). HIAA represents 269 member companies providing health, long-term care, disability income, and supplemental insurance coverage to over 115 million Americans. I appreciate this opportunity to appear before you today to discuss the relationship between health care costs and America's uninsured.

Study after study shows that the cost of health coverage relative to family income is the most significant factor affecting whether or not people have insurance coverage. In response to double-digit health care inflation in the 1980s, employers became much more aggressive purchasers of health coverage. Together with insurers, employers drove innovation in the private market that benefited consumers (largely their employees) through lower premium increases, new health plan options, and enhanced coverage for preventive care and other benefits. Without these changes, millions more Americans would lack health insurance coverage today.

Despite this progress, health care costs have continued to rise and will continue to rise for the foreseeable future. Technological progress, breakthrough medical devices and prescription drugs, improvements in medical procedures, as well as the general aging of the United States' population all have contributed to this growth. Managed care can help shield consumers from the impact of these cost drivers, but there are some costs that will remain beyond the control of most employers and insurers. Moreover, as both the states and the federal government more aggressively pursue so-called "patient protection' legislation and other mandates, there is mounting evidence that these "reforms" also have increased costs and added significantly to the ranks of the uninsured.

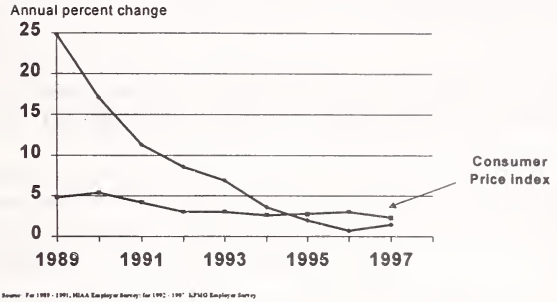
I should also note that, while there is a symbiotic relationship between health care costs and health care premiums, these concepts are not the same. The underlying costs of care do have a significant and direct impact on premiums, but there also are other factors that may exacerbate (or mitigate) premium trends.

Employers and Health Insurers Have Collaborated to Help Contain Costs and Improve Health Care Quality

Employers have been the driving force in helping to contain health care costs and improve quality during the past decade. Large employers in particular began demanding relief from double-digit premium increases they faced in the 1980s.

As a result of employer demand and health plan innovation, the nation has experienced a dramatic decline in the growth of health insurance premiums over the past ten years. Double-digit inflation in excess of 20 percent in the late 1980s dropped dramatically to low single digit rates in the late 1990s, more in line with general consumer price index trends.

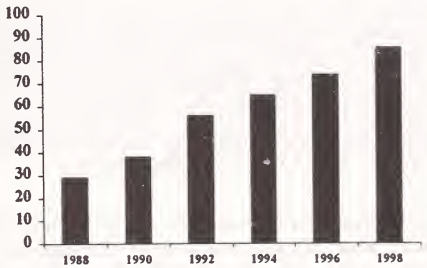
Employer Premiums: Dramatic Fall in Rate of Increase



This decline in premium growth during the 1990s coincides with dramatic increases in market penetration of managed care. Enrollment in PPOs, HMOs, and other forms of managed care has tripled during the past 10 years from 29 percent in 1988 to 86 percent in 1998.

Growth in Managed Care

(percent)

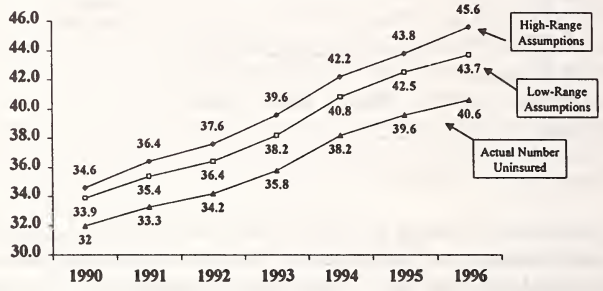


Source: KPMG Health Benefits Survey for years: 1992 - 1998
HIAA for years: 1988 - 1990

It is estimated that the impact of lower insurance prices attributable to this trend saved consumers somewhere between $24 billion and $37 billion in 1996. This savings is projected to grow to between $125 billion and $200 billion by the year 2000.

In fact, without these savings, some employers would not have been able to afford private insurance and would have been forced to discontinue coverage for their workers. Lower premiums resulting from managed care has reduced the current number of uninsured by between 3 and 5 million people.[1]

Number of Uninsured Under High- and Low-Range Managed Care Savings Assumptions (in millions)



Source: Lewin Group estimates based upon Current Population Survey Data for 1990 throug 1996

The foundation for the current employment-based health care system was laid during the Second World War. In response to wartime wage controls put in place to prevent companies from raising wages, employers began offering more generous health insurance and other non-cash fringe benefits to their employees and deducting such costs as normal business expenses under section 162 of the tax code. In 1943, the Internal Revenue Service ruled that employer contributions toward premiums for group health insurance were not taxable to employees. This ruling was codified in 1954.

Passage of the Employee Retirement Income Security Act of 1974 (ERISA) helped make it easier in many respects for large, multi-state employers to manage benefits and further cemented the relationship by which millions of workers receive health benefits through employer-sponsored plans. One of the key reason that employers have been able to help spur innovation and cost savings is the regulatory flexibility and national uniformity provided through the ERISA framework. This committee played a key role in enactment of that landmark legislation. As a result of a favorable regulatory environment and private sector innovation and efficiency, the number of people covered by group health insurance has grown from less than 12 million in 1940 to over 152 million today.

[1] Sheils, John F. and Haught, Randall A., "Managed Care Savings for Employers and Households: Impact on the Uninsured," June 1997, The Lewin Group, Inc. for the American Association of Health Plans.

While the private employment-based health care system is firmly rooted in its historic past, it has been overwhelmingly successful in providing coverage to millions of Americans even during times of rapidly increasing medical costs and swift improvements in medical treatment. This is in part because employer groups— particularly large employer groups—do a very good job of pooling health care risks, encouraging large percentages of employees and dependents to participate in their health plans, and spreading the costs of coverage among both healthy individuals and those that incur greater health costs.

Overall, the employment-based system has been remarkably effective in covering working Americans and their dependents. Nine out of ten firms with more than fifty employees offer health coverage as an employee benefit. Even among smaller firms, one out of two offer health care coverage as an employee benefit.[2]

Despite growth, in health care costs, employers efforts to control health care costs by fostering price competition have directly benefited workers, especially those low-wage workers who otherwise would be unable to purchase coverage.[3]

Employers also have a key role in ensuring the quality of the health care purchased on behalf of their employees. As Roger Evans, manager of the health services evaluation section at the Mayo Clinic notes, "[r]eform is being driven by progressive employers, by those concerned about quality . . . They are the ones driving positive changes and those changes benefit not only the employers involved, they also help improve the entire care-delivery system for everyone."[4]

Employers are involving themselves in the health care system in a variety of ways, both direct and indirect.[5] For examples, General Motors Corp., Fort Motor Co., Chrysler Corp. and the United Auto Workers recently collaborated in a six-month effort to develop a common quality report card for health plans offered to employees of the Big Three automakers,[6] and the Pacific Business Group on Health has made strides to improve quality by negotiating specific performance guarantees with health plans.[7] Many other examples of quality improvement initiatives initiated by both business coalitions and

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[2] Employment-Based Health Insurance: Medium and Large Employers Can Purchase Coverage, But Some Workers Are Not Eligible, GAO/HEHS-98-184

[3] Kronick, Richard and Gilmer, Todd (1999): "Explaining the Decline in Health Insurance Coverage, 1979-1995", *Health Affairs*, 18(2), 30-47

[4] The Business Roundtable, The Spillover Effect: How Quality Improvement Efforts by Large Employers Benefit Health Care in the Community, The Business Roundtable Health and Retirement Task Force, June 1998, http://www.brtable.org/pdf/160.pdf

[5] Christianson, Jon B., "The Role of Employers In Community Health Care Systems", *Health Affairs*, 17(4), 158-164

[6] White, Joseph B., The Wall Street Journal, October 19, 1998

[7] Schauffler, Helen Halpin; Brown, Catherine; and Milstein, Arnold, "Raising the Bar: The Use of Performance Guarantees by the Pacific Business Group on Health", *Health Affairs*, 18(2), 134-142

individual employers are available.[8] Many employers, recognizing the business value of healthy employees, are going beyond the traditional health benefit program to establish worksite health promotion programs, employee assistance programs, health and productivity management programs, and even in some cases worksite primary care centers.[9]

Despite Private Sector Innovations and Cost Containment, the Number of Uninsured Continues to Climb

Despite recent innovations in the marketplace that have expanded consumer choice, improved quality, and provided lower cost insurance options, the number of Americans without health insurance coverage has continued to climb throughout the last decade. Currently, 168 million nonelderly Americans enjoy the security of private health insurance; and the vast majority gets its coverage at the workplace. But for too many Americans, private health insurance is unaffordable, and often, government programs like Medicaid do not cover these needy adults.

Today, there are over 44 million uninsured Americans. By the end of the next decade that number will grow to at least 53 million - one in every five nonelderly Americans. If the economy sours, one in four working-age Americans and their families could find themselves without health insurance coverage.[10] Clearly, this is a disturbing trend that we, as a nation, cannot afford to let continue.

Last month, the HIAA Board of Directors approved a major initiative to help address this issue. The InsureUSA plan to increase health coverage combines targeted subsidies, tax incentives, cost-control measures, and education. Importantly, it builds on the foundation of the private employer-based system while recognizing that government also has an important role. We already have provided a copy of our plan to all members of Congress, including members of this subcommittee. Additional information about the plan and about the uninsured may be found at a special website we have developed, www.InsureUSA.org. And, of course, HIAA staff would be happy to meet with members of Congress at any time to discuss our proposal, and other ways to expand health insurance coverage, in more detail.

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[8] The Business Roundtable, The Spillover Effect: How Quality Improvement Efforts by Large Employers Benefit Health Care in the Community, The Business Roundtable Health and Retirement Task Force, June 1998, http://www.brtable.org/pdf/160.pdf

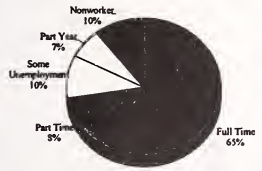
[9] Grosch, James W. et al., American Journal of Health Promotion, September/October 1998
American Productivity & Quality Center and The MEDSTAT Group, Best Practices in Health and Productivity Management, 1998
Pruter, Robert, "Primary Care Centers: A New Concept in Employer-sponsored Health Care Facilities", *Employee Benefit Plan Review*, March 1998

[10] Custer, William S., "Health Insurance Coverage and the Uninsured," December 1998, Center for Risk Management and Insurance Research, Georgia State University, for the Health Insurance Association of America.

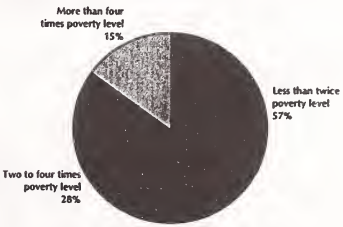
Mr. Chairman, from research sponsored by HIAA and others, we know that low-income Americans are particularly likely to be uninsured. Almost two out of every three uninsured Americans (57%) below the age of 65 lives in a family with an income that is less than two times the federal poverty level. Many uninsured do not qualify for government assistance; and two out of three uninsured Americans live in a family headed by a full-time worker.

Some work for small firms, which are unlikely to offer coverage; others have access to employer-sponsored coverage but cannot afford the employee contribution. .[11]

Most Uninsured Live In Families Headed by a Full-Time Worker



For Uninsured Americans, Affordability Is the Obstacle to Coverage



Source: William S. Custer, Ph.D., Center for Risk Management and Insurance Research

While the uninsured have many faces, the major reason that Americans are uninsured is because they simply cannot afford coverage. As Dr. William Custer noted in a December 1998 study on behalf of HIAA, the primary reason for the increase in the number of Americans without health insurance over the last 15 years has been the increase of health care costs relative to family income. Just as national health care expenditures have increased as a proportion of Gross Domestic Product so have personal health care costs increased as a proportion of family budgets. As these health care costs increased, families decreased their purchase of health care services-especially of health insurance.[12] Other researchers have reached similar conclusions.[13]

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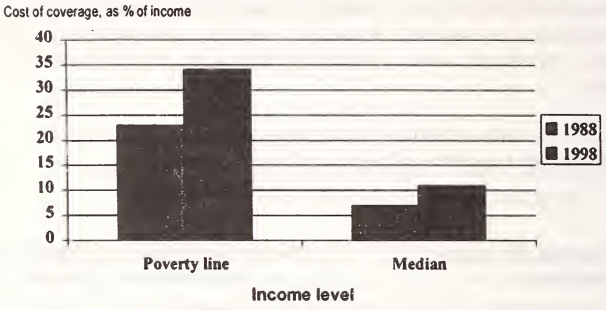
[11] Custer, Ibid.

[12] Custer, Ibid.

[13] In the March/April 1999 issue of Health Affairs (Volume 18, number 2), there are two pieces that argue that declines in coverage are due to increases in per capita health care spending relative to per capita incomes. The first, entitled "Explaining the Decline in Health Insurance Coverage, 1979-1995", is by Richard Kronick and Todd Gilmer. The primary conclusion of this study is that "the sharp declines in insurance coverage among workers from 1979 to 1995 can be accounted for almost entirely by the fact that per capita health care spending increased more rapidly than income over this period."

The second article on this topic is a Datawatch piece by Kenneth Thorpe and Curtis Florence, entitled Why are Workers Uninsured? -- Employer-Sponsored Health Insurance in 1997. The authors review the Contingent Worker Supplement (CWS) to the February 1997 CPS. The key fact provided by the study is that "[o]f the 2.5 million uninsured workers eligible for employer-sponsored coverage, nearly 68 percent

Affordability Has Fallen



Source: HIAA calculations for a family of four, using KPMG cost data

Health Care Cost Drivers

As noted above, the number of uninsured would be even higher without the growth of managed and other private sector innovations that have occurred primarily in the employment-based market during the past decade. Yet, even though rates of growth have slowed, health care costs continue to climb. Improved health care technologies, procedures, and pharmaceuticals, combined with immutable demographic trends, have contributed to inexorably climbing health care costs. Let me briefly discuss a few of the most significant cost drivers we as a nation, and as health insurers, are confronting.

The Growing Importance and Cost of Pharmaceuticals

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cited high cost as their reason for rejecting it." Interestingly, only 1.1 percent of workers who were unable to obtain coverage cited a pre-existing health condition as the reason.

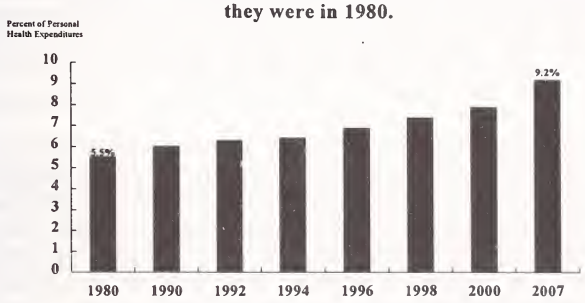
See also, General Accounting Office, "Private Health Insurance: Continued Erosion of Coverage Linked to Cost Pressures," July 1997, GAO/HEHS-97-122.

It is important to note that an inability to qualify for coverage as a result of poor health is not the primary reason people lack health insurance. Donelan, Karen, et al, "Whatever Happened to the Health Insurance Crisis in the United States," Journal of the American Medical Association, October 23/30, 1996, vol. 276, no. 16. Among the key results of the study is that "[c]ost and the lack of employer-provided coverage are the principal reasons for being uninsured." Only one percent of the uninsured reported that they were unable to obtain coverage due to a preexisting medical condition.

Pharmaceuticals contribute to improving the lives and health of many patients, and new research breakthroughs in the coming years are likely to bring even greater improvements. At the same time, the rapid increase in both the price and utilization of outpatient prescription drugs (and projected increase) could make pharmaceutical coverage in particular and health insurance in general less affordable.

Prescription drug expenditure growth now outpaces other categories of health spending, including hospital and physician costs, and is expected to comprise over nine percent of all personal health expenditures by 2007—almost double what it was in 1980.

Prescriptions drug expenditures are projected to climb to over 9% of all personal health expenditures, almost double what they were in 1980.



Source: Health Care Financing Administration

Moreover, hospital and physician costs have continued to climb despite increases in drug spending. As the rates of increase in health spending in most categories of expenses have declined, the rate of growth for pharmaceuticals and, especially, for prescription drugs has increased. Prescription drug expenditures now outpace all other major categories of health expenses, increasing at over 14 percent in 1997.

Prescription drug expenditure growth now outpaces other categories of health spending

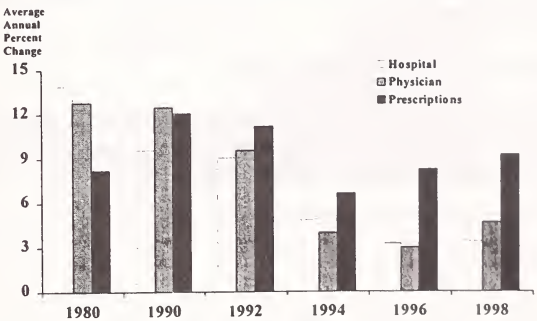


Figure 2

Source: Health Care Financing Administration

Advances in Technology

While managed care has given purchasers some control over price growth in health care over the last decade and economy-wide inflation continues to decelerate, growth in non-price factors continue at essentially the same rate. Growth in volume and intensity of use per capita has remained the same throughout the 1990s, representing about 35 percent of the increase in the growth of per capita health spending between 1995 and 1997.

The introduction of new medical technologies have the potential to improve health outcomes and, eventually, to decrease spending in other areas over time. However, new technologies almost always have the immediate effect of increasing services and potentially costs for an area of services. For example, MRIs (which may detect certain conditions earlier than other types of tests) cost about twice as much on average as CAT scans, yet both are now considered essential as diagnostic tools. Laparoscopic procedures replace traditional surgical procedures at greater surgical costs (e.g., cholecystectomies, or gall bladder removals average $1,800 by traditional methods compared with $2,200 by laparoscopic method) but often result in shorter hospital stays.

Other new technologies do not replace other methods of care or service at all, but add entirely new costs (and benefits) for society. For example, mapping human gene codes through the research sponsored by the human genome project has the potential to help doctors detect and treat disease earlier. This activity also will lead to increased utilization of care and, hopefully, better preventive care in the future. Similarly, improved hearing screening tests for newborns have the potential to save children years of therapy, but will add immediate costs to the system.

The Aging Society

The aging of the U.S. population also has contributed to growing health care costs. Per capita treatment costs tend to increase with age, and the U.S. population is steadily aging. Median age has increased from 30 years in 1980 to 34.9 in 1997. The percentage of the population in age cohorts that have traditionally increased in size (ages 35 to 54) will start to decline with increasing population percentages in older age cohorts. Fifty-five to sixty-four year olds will increase from 8.2 percent in 1997 to 11.9 in 2010, almost a 50 percent increase. While the greatest impact of an aging society may fall on the Medicare and Social Security programs, it also has important cost implications for employer-sponsored and retirement health plans.

Litigation Costs and Defensive Medicine

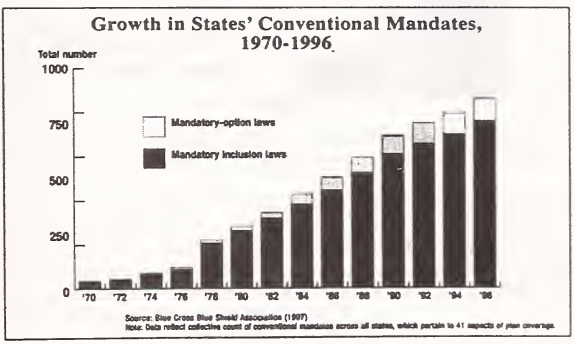
Estimates of the cost of defensive medicine, tests and procedures performed or ordered by physicians to protect themselves from malpractice claims, ranging from $5 billion to $50 a year, amount to roughly 3 percent of health care spending.

A Stanford study in 1995 concluded that in states that adopted reforms limiting liability awards, hospital outlays slowed appreciably, lowering such expenditures by 5 percent to 9 percent relative to the levels reached in other states with no reforms. A May 13, 1996 Business Week article reporting on the 1995 Stanford study wrote "... the recent slowdown in U.S. medical expenditures may partly reflect the malpractice reforms adopted by many states over the past decade – as well as the huge growth in managed-care plans, which closely monitor physicians for signs of excessive use of tests and costly treatments."

Nonetheless, only a relatively small number of states have put in place effective controls on malpractice lawsuit abuse. Therefore, this will continue to be an area that contributes to health care growth into the next century. Moreover, as my testimony below highlights, legislators increasingly are seeking to expand the liability of health plans and employers. If these effects are successful, they will further exacerbate cost pressures resulting from litigation.

Benefit mandates

One of the major reasons for growing costs and the resulting increase in the number of uninsured has been the proliferation in government benefit mandates, particularly at the state level. According to a recent study by Gail Jensen, Ph.D. and Michael Morrisey, Ph.D for HIAA, nearly one out of every four uninsured Americans have no health coverage because of the cost of state mandates.[14] According to Jensen and Morrisey, there was at least a 25-fold increase in the number of state mandates on health plans between 1970 and 1996. These mandates have raised premiums by up to 13 percent for businesses that offer health insurance to their employees, and the lion's share of the cost of these mandates has been borne disproportionately by workers in small businesses. Eighteen percent of small businesses without health coverage would buy it in the absence of state mandates.[15]



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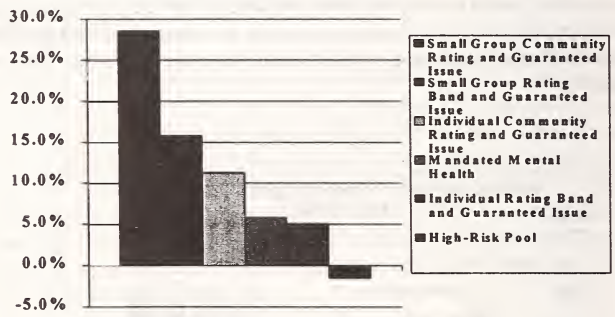
The Jensen-Morrisey study also reviewed the impact of specific mandates on employers offering health coverage. The study found that, on average, premiums would increase: 15 percent for mandated coverage for routine dental services; 13 percent for mandated coverage for psychiatric hospital stays; 12 percent for mandated coverage for visits to psychologists; and 9 percent for mandated coverage for chemical dependency treatment for employer-sponsored health plans that do not voluntarily provide coverage these services.

Similarly, the study by Dr. William S. Custer, noted above, found a strong correlation between lack of insurance coverage in certain states and certain types of regulation. That study shows that state regulations, primarily coverage mandates and small group reforms, have contributed to the rising number of uninsured Americans. For example, small group community rating along with guaranteed issue increased the probability of an individual being uninsured by 28.5 percent. Small group rating bands along with guaranteed issue increased the probability of an individual being uninsured by 15.8 percent. Community rating along with guaranteed issue in the individual market increased the probability of an individual being uninsured by 11.3 percent. And mandatory coverage of mental health increased the probability of an individual being uninsured by 6 percent.

State Reforms Have Contributed to the Likelihood of Being Uninsured



Other studies have reached similar results.[16]

Legislative Threats, Particularly Erosion of ERISA in So-Called "Patient Protection" Legislation

While the majority of adverse legislative activity has taken place at the state level, members of Congress have become increasingly active during the past few years in promoting legislation that would have significant detrimental impacts for health care consumers, employers, and health insurers.

So-called "patient protection" legislation and other similar initiatives threaten to unravel the employment-based private health care system itself by attacking its legislative cornerstone—ERISA. HIAA continues to oppose any legislation in this area. We believe that helping to insure more Americans by making coverage more affordable should be "job one" for Congress. So-called "patient protection" legislation would move us in the opposite direction. It would drive up health care costs, increase the number of uninsured, and could destroy the fabric of the employment-based system through which nine out of ten privately insured Americans currently get their coverage.

In particular, subjecting health plans to expanded liability for state malpractice damages by removing ERISA preemption would have devastating consequences. It would increase costs by eroding the ability of health plans to employ effective utilization review and utilization management. It also would reduce incentives to control costs by compelling plans to cover inappropriate or unnecessary services to protect themselves from liability. Expanded tort liability will cause health care premiums to rise anywhere form 2.7 percent to 8.6 percent, depending on the type of health care delivery system affected. Overall health spending would increase by $123 billion over five years.[17] A survey by the National Association of manufacturers found that over half would reduce coverage or drop health insurance altogether if ERISA preemption were modified to allow health plans to be sued for tort damages in state court.

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[16] Marsteller,Jill et al., "Variations in the Uninsured: State and County level Analysis," June 1998, The Urban Institute.

Schriver, Melinda and Arnett, Grace-Marie, "Uninsured Rates Rise Dramatically in States with Strictest Health Insurance Regulations," August 1998, The Galen Institute/Heritage Foundation.

Buchanan, Joan and Marquis, Susan, "Who Gains and Who Loses with Community Rating for Small Business?" This study concludes that "[u]nder community rating, those in poor health tend to insure, while those in better health go bare. The opposite occurs under experience rating, the healthy buy insurance and the sick go bare. Our estimates suggest that the increase in the coverage of the sicker families under community rating may be at the cost of an overall decrease of about five percentage points in the number of working families participating in employer group plans."

[17] AAHP, Barents Group "Impact of Four Legislative Provisions on Managed Care Consumers: 1999-2003, April 1998.

We also have written extensively about the additional costs consumers would be forced to bear if Congress gave physicians carte blanche over "medical necessity" coverage decisions.[18] It is important to note that while proponents of these legislative initiatives argue that they are intended to reform "HMOs," infact, liability and medical necessity legislation and other "patient protection" mandates will increase costs for all types of health plans, from indemnity carriers to PPOs, to HMOs.

Conclusion

The health insurance industry, working with employers, has been extremely effective in recent years in slowing premium increases, improving health care quality, and expanding coverage in the employment-based market. Yet, without additional financial support from the government, a growing number of low-income Americans will continue to lack health insurance coverage. In addition, a series of legislative initiatives being considered at both the state and federal level, would put affordable private coverage out of reach for even more American.

We look forward to working with the members of this subcommittee, and other members of congress, to help find ways to expand health coverage in months and years ahead.

Mr. Chairman, that concludes my testimony. I would be happy to answer any questions you may have.

[18] " "Medical Necessity" and Health Plan Contracts," March 1999, Health Insurance Association of America.

APPENDIX I - WRITTEN STATEMENT OF SAL RISALVATO, OWNER, RIVERDALE TEXACO, RIVERDALE, NJ ON BEHALF OF NATIONAL FEDERATION OF INDEPENDENT BUSINESS, WASHINGTON, DC

Statement of
SAL RISALVATO
OWNER
RIVERDALE TEXACO
RIVERDALE, NJ

On behalf of the National Federation of Independent Business (NFIB)

Subject: The Increasing Cost of Health Insurance for Small Businesses

Before: House Education and the Workforce Committee
Employer/Employee Relations Subcommittee

Date: June 11, 1999

National Federation of Independent Business
600 Maryland Avenue S.W., Suite 700 • Washington, DC 20024 • 202-554-9000 • Fax 202-554-0496

Good morning Mr. Chairman, and members of the committee. Thank you for inviting me here today, so I may explain to you the difficulty experienced by small business owners who want to provide health care benefits for their employees. I plan to give you my personal history in the health care marketplace. Also, I would like you to know that I have been involved in this issue since 1986, and have had many other small business owners share their experiences with me. The organization I have shared these experiences with is the one organization that truly has the best interests of small employers and the American public at heart. The NFIB has always fought to help small employers find ways to afford to provide health care coverage for their employees. This is an effort that continues today, and remains a top concern of those that own their own business and employ most of the workers in our country.

I am sure that all members of this committee recognize that small business employs most of the workforce in the United States. There is not a lot of need to go through all of the statistics and fanfare about how small business is the engine that drives our economy. Congress has for years recognized the importance of small business to our economy. I only wish Congress would act as if small business is important, and not just say small business is important. If we solve the problem small business has of trying to pay for the health care benefits of their employees, we will solve much of the problem with uninsured Americans.

Bigger business cannot be looked to as a means to solve this problem. Big business increases their profits by eliminating workers. Small business increases profits by expanding markets, and hiring workers. Yesterday, Proctor and Gamble announced the elimination of 15,000 jobs. Where will those 15,000 people find work? Most likely they will either find employment with a small firm that is growing and expanding, or will start their own enterprise. They will start out like most of us, as a one-man band, that grows, expands, and hires other workers that are discarded from big corporations. These one man bands and their few employees will need health benefits. Since they will be in a different situation and a different market than they were used to at Proctor and Gamble, they will be faced with making the decision of whether or not to have health care coverage. We as a nation and you in Congress need to provide as many incentives as possible while removing roadblocks that get in the way of offering affordable coverage.

I started in business when I was 18 years old. I started with a small landscape company, and after a few years moved on to the automotive business. I have owned a service station in New Jersey for 21 years, 2 months and 8 days. I have been a staunch supporter of the free enterprise system, and have never

held a job for anyone else but myself. I have utilized all of the tools of the capitalist system available to me to compete for both customers and employees. One of the tools I have used since 1983 to compete for my full time workers since then, and have even chosen to pay for them entirely. To this day I have never deducted a penny from an employee for health care benefits. I am very proud of that. Please understand, however, this has not been easy to accomplish.

By 1986, sharp rises in cost made me reconsider the wisdom of my three-year-old decision. I had already begun questioning the wisdom after the first year of providing health care benefits when I learned from my accountant I was not permitted to deduct the portion of the premium that I had paid for my own coverage. Of course I did not learn about this until it was time to file a tax return. I had never even considered a ridiculous tax policy like that could exist. Common sense told me it was an expense and that I should deduct it. Unfortunately, not all tax law requires common sense.

I started to get angry and vocal about the sharp increase in premiums I had received. I was confused why something so important was not more competitive and affordable. I was receiving similar complaints from other small business owners. My industry still was not in tune to providing these benefits, which was the reason I started to provide them in the first place. I was providing something that my competition was not. Initially, providing this benefit was less expensive than providing a pay increase. In fact, businesses large and small utilized this tool as an added means of rewarding and compensating employees. This actually started the problem of rising costs, because Americans began receiving unlimited amounts of health care but were not directly paying for it.

When more policies began giving benefits such as prescription coverage and eyeglass coverage under fee-for-service plans, premiums began to rise as there was no control on the final cost. The consumer, or in this case the patient, many times did not even know the cost of the final bill. Nor did they care to know. The patient paid their deductible, which was at that time usually very low and off they went. When one pays $250 for a service or product that could have a final price tag worth thousands of dollars, one may feel that one received one heck of a bargain. With the end user having little if any responsibility to control these costs, an upward and uncontrollable escalation of premiums resulted. Since insurance companies were obligated to pay the claims, provider fees escalated. The cost to provide medical services ballooned. As long as fees were billed at what was then known as "usual and customary" the insurance company was obligated to pay. Reflecting on this process, I believe the term "usual and customary" was nothing more than legalized price fixing.

Without anything in place to make the market work in both the providing of health care, and the access to health care coverage, premiums

continued to rise at a rate much higher than the rate of inflation. In many instances rate increases were 15% to 20% per year, every year. Of course, with premium increases like that employers reacted in many different ways. Many opted to drop coverage, while many opted to decrease coverage by increasing deductibles and eliminating services and procedures covered under the policy. Still, many opted to either start requiring employees to contribute all or a percentage of the premium, or increased the percentage the employee was already paying.

This did, however, start to get the attention of all Americans. When employees started paying the cost of health insurance and also higher deductibles, they began playing the role of an educated consumer, not just a patient. The debate began, with employees blaming employers, and employers blaming insurance providers, and insurance providers blaming medical providers, and medical providers blaming lawyers, and everyone blaming the government.

By the time 1991 rolled around I had considered dropping health benefits every year I had been in business, simply because I could not afford coverage. In fact, on April 30 1992, I testified before this committee when it was then under a different committee title and different leadership, and talked about the dilemma my colleagues and I were facing. I asked this committee to consider reforms that would create incentives to help drive down the cost of health care premiums. I asked for nothing more than reforms that follow the guidelines and principles that have made every other American product and service the best on earth with the best and most competitive price. Those principles were market based and free enterprise based, and sought to remove the shackles of government.

The day after I testified before this committee, I retumed to my office only to find that while I was in Washington D.C. the mailman had delivered a notice from my health insurance carrier that my premium would be increased 30%. Oh how I wished that notice had arrived one day earlier. Even though the national debate had started, and was a focal point of political topics during the 1992 presidential election, small business was still faced with the high cost of providing health care coverage for their employees. The amount of Americans that are uninsured has risen from 30 million to 43 million. A large part of the cost increase has resulted from Americans with insurance coverage paying the health care cost of those Americans without health insurance. Since most uninsured Americans are employed by small business, it is imperative to find solutions that help small business provide coverage. Please take note that I said "help" and not "require". I will address that issue later.

Not all the historical news regarding health care premiums is bad. Let's point out the good with the bad. After the nation had the heated debate in 1994, and breathed a collective sigh of relief when the Clinton Health Care Plan was defeated, the newly found consumer awareness pertaining to health care costs helped to slow the rise in medical inflation. In fact medical costs for the first time

in over a decade grew at about 5%, much closer to the rate of inflation. My own personal experience was better than that. I received a premium decrease that equaled 15% (although still 15% above the 1991 level). I had modest if any increases for 1996 and 1997. But the premium monster is back. I have had increases of 20% each of the last two years.

So now I am back to switching insurance companies, lowering coverage, and considering an employee contribution. Since only a few of the reforms the small business community has been asking for have been implemented, I am back before you asking you to please keep your eye on the again rising health care premiums, and to please make the reforms needed in order to drive down cost.

A frequently discussed issue that I am often asked about is the deductibility of health care premiums. Many small business owners are puzzled by the fact they cannot deduct 100% of the premium that they pay for themselves. Like I said earlier, I did not know of this unfair policy when I started to provide coverage. I honestly still do not know if I would have provided coverage if I had known in advance and, in fact, probably would not have. I often wonder, "how many employers are discouraged from providing benefits because of this unfair tax policy?" Yes, I thank Congress for changing the policy and phasing in a 100% deduction. No, I do not think it is fair to wait until 2003. Nor do I think it will be an incentive to small business owners to start providing coverage for their workers unless we phase it in now.

By supporting Association Health Plans (AHPs), small business owners will have access to health care markets unavailable to them now. AHPs, will give small business owners the freedom to design more affordable benefit options, and offer workers more choices. Allowing small business to band together across state lines to purchase health insurance will allow them to enjoy the same economies of scale now realized by big business. Group purchasing is always better than individual purchasing.

Congress can help keep premiums from rising by opposing any new mandates that would require employers to pay for coverage like substance abuse, contraceptive and reproductive procedures, and certain cosmetic procedures. Mandates of any kind only add to the cost of health care premiums. Certainly any mandates that require employers to provide coverage will be serious. By mandating coverage you take away the small business owner's freedom, you eliminate his choice. There are many times a small business owner is faced with making important decisions about which bill to pay first. If health care were mandatory, many small businesses would be faced with not being able to pay expenses that are critical to the overall operation, like rent, and utilities.

If Congress were to support reform that encourages small business owners to provide coverage, the result would be more Americans receiving coverage. The more Americans covered, the lower costs will go down. The more costs go down, the more small business will be able to afford to provide coverage. When more small businesses can afford to provide health care coverage, the more small business will have the necessary tools to attract and maintain quality workers. The spiral will finally turn in the opposite direction. Please help me to continue providing health care benefits for my employees, and please help my small business colleagues that do not currently provide coverage to be better able to do so.

Thank you again, for allowing me the opportunity to testify here today. I will be happy to answer any questions you may have.

APPENDIX J - SUBMITTED FOR THE RECORD, WRITTEN STATEMENT OF MERRILL MATTHEWS, JR., Ph.D., VICE PRESIDENT-DOMESTIC POLICY, NATIONAL CENTER FOR POLICY ANALYSIS, WASHINGTON, DC

House Committee on Education and the Workforce
Subcommittee on Employer-Employee Relations

"The Relationship between Health Care Costs and America's Uninsured"

June 11, 1999

Written Testimony of
Dr. Merrill Matthews, Jr. Ph.D.
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How Government Is Causing Our Nation's Health Care Crisis

Merrill Matthews Jr., Ph.D.
National Center for Policy Analysis

There is a growing sense that Congress must act in order to stem the growing tide of people who lack health insurance — now at about 43.4 million people.

A common assumption behind most health care reform proposals is that the private sector is causing our national health care crisis. Many Republicans and Democrats persist in seeing the problems as originating outside of Washington. However, government rather than the private sector is creating our health policy crisis by: (1) providing distorted tax subsidies for health insurance; (2) imposing mandates on health insurance and health plans; and (3) making it increasingly easy to get health insurance after a person gets sick.

If we really want to do something about the uninsured, we need to address the way federal policies are creating the problem.

Federal Tax Subsidies

Health care spending is on the rise once again, driving up the cost of health insurance and driving many lower-income people into the ranks of the uninsured. A primary reason why health care spending is out of control is that most of the time when we enter the medical marketplace as patients we are spending someone else's money rather than our own. Economic studies — as well as common sense — confirm that we are less likely to be prudent, careful shoppers if someone else is paying the bill.

The Extent of Third-Party Payment of Medical Bills. Although polls show that most people fear they will not be able to pay their medical bills from their own resources, the reality is that few of us will ever have to. On the average:

- Every time we spend a dollar in a hospital, we pay only 3 cents out-of-pocket, and 98 cents is paid by a third party (employer, insurance company or the government).
- Every time we spend a dollar on physicians' fees, we pay less than 15 cents out-of-pocket.
- For the health care system as a whole, we pay only 18 cents out-of-pocket every time

we consume a dollar's worth of services.

Moreover, the explosion in health care spending over the past three decades parallels the rapid expansion of third-party payment of medical bills. The patient's share of the bill has declined from 52 percent in 1965 to 18 percent today.

Why the phenomenal growth in third-party health insurance? Tax subsidies.

Tax Subsidies for Third-Party Insurance. In most insurance markets, insurers pay only in the case of risky events — events not under the control of policyholders. Moreover, high deductibles are common. Health insurance is different. Insurers often pay routine expenses (for checkups, diagnostic tests, etc.) unrelated to risky events, and low deductibles are common. There is nothing normal or natural about the way the health insurance market functions. It is the result of perverse incentives created by the tax law.

Under current law, every dollar of health insurance premiums paid by an employer escapes, say, a 28 percent income tax, a 15.3 percent Social Security (FICA) tax and a 4, 5 or 6 percent state and local income tax, depending on where the employee lives. The government is effectively paying half the premiums — a generous subsidy that encourages employees to overinsure.

Penalties for Individual Self-Insurance. Most individuals and families would be much better off if they had the opportunity to choose high deductibles and place the premium savings in a bank account — to use for small medical bills. Yet, while the federal government generously subsidizes third-party insurance, it discourages self-insurance by heavily taxing funds that individuals put aside for medical expenses.

Two exceptions to this general rule are that federal tax law permits employees to make pretax deposits to Flexible Spending Accounts (FSAs) from which to pay for medical expenses not covered by employer-provided health insurance. These accounts are governed by a use-it-or-lose-it rule, however. Within a certain time period, usually a year, employees must spend all funds in the account or forfeit them. FSAs, then, are designed to encourage spending, not restraint.

In addition, Congress has approved a limited Medical Savings Account (MSA) demonstration project. MSAs are similar to FSAs, but without the use-it-or-lose-it provision. Unfortunately, restrictions on the MSAs have kept them from being as attractive a product as they otherwise would.

The federal government could make major progress in eliminating the distortions in federal tax law by giving just as much tax incentive to individual self-insurance as it now gives to third-party insurance. Without this change, there is little reason to think health care costs can

be controlled without government-imposed health care rationing.

Government Mandates

Congress and state legislatures are increasingly inserting themselves in the health insurance marketplace by imposing a range of regulations. One way they do that is with health insurance mandates, which require health insurance policies to cover what politicians want them to cover, rather than what employers or patients want them to cover.

Health Insurance Mandates. For more than 30 years, state legislatures have passed laws driving the cost of health insurance higher. Known as mandated health insurance benefit laws, they force insurers, employers and managed care companies to cover — or at least offer — specific providers or procedures not usually included in basic health care plans.

While actuaries, insurers and health economists agree that virtually all mandates increase the cost of health insurance, the magnitude of their effects has been subject to debate. For example, a 1997 analysis prepared for the National Center for Policy Analysis by the actuarial firm Milliman & Robertson estimated the costs of 12 of the most common mandates and found that, collectively, they can increase the cost of insurance by as much as 30 percent.

The Explosion of Mandated Benefits. Although there were only seven state-mandated benefits in 1965, there are more than 1,200 today. While many mandates cover basic providers and services, others require coverage for such nonmedical expenses as hairpieces, treatment for drug and alcohol abuse, and pastoral and marriage counseling.

These mandates apply only to those health insurance policies controlled by state health insurance laws — usually policies purchased by small businesses and individuals. Most large companies avoid state mandates by self-insuring under the Employee Retirement Income Security Act (ERISA), which exempts self-insured companies from state oversight. However, the federal government has recently gotten into the mandate business — banning "drive-through" baby deliveries and requiring that any cap on mental health benefits be the same as the cap on physical health benefits — which apply to all insurance. Moreover, Congress appears likely to pass even more mandates in the future.

Who Pays for Mandated Benefits. Many employees believe their employers pay for the insurance they provide. However, economists recognize that employee benefits are a substitute for wages in the employee's total compensation package. Higher benefits often force employees to take lower wages whether they like it or not. A 1990 survey of the literature by National

Bureau of Economic Research economist Olivia S. Mitchell found that the cost of mandated benefits is usually borne by employees in the form of reduced wages, reduced work hours or loss of employment.

The Impact of Mandates. When employers who canceled their employees' health insurance policies have been polled on why they did so, the majority claimed that it was because the price was too high. While mandated benefits mean that people with health insurance have more health care options, they also mean that fewer people are insured.

Government Regulations Affecting Access

After several years of relatively low growth in health care costs — and, as a result, relatively low growth in the percentage of uninsured — some policy analysts fear that health insurance premiums may grow by 8 to 10 percent in 1999.

In response to these increases, many want the government to ensure universal access to health insurance at affordable prices. The truth is that the growth in health care costs and the uninsured is a direct result of government intervention at the federal and state levels. The common denominator among the health care policy failures is a government that tries to make health insurance available to anyone regardless of their health, a practice known as "guaranteed issue."

Guaranteed Issue in the Kassebaum-Kennedy Health Insurance Reform Bill. The Kassebaum-Kennedy bill passed in 1996 created guaranteed issue for small businesses. Thus small employers who might have been denied a group health insurance policy because one or more employees had a costly medical condition must be accepted. In addition, those with group health insurance who leave their jobs and need to purchase individual health insurance cannot be denied coverage.

During the debate over the bill, the American Academy of Actuaries suggested that premiums might rise between 2 and 5 percent. Proponents of the legislation quickly seized on the lower number to suggest that Kassebaum-Kennedy benefits outweighed its costs. However, those who closely examined the Academy's analysis found it showed that some premiums would eventually increase between 125 and 167 percent. The subsequent study by the General Accounting Office verified the prediction.

Guaranteed Issue in New York. The New York legislature passed a bill in 1993 that

required both guaranteed issue and "community rating," in which everyone is charged the same premium. To achieve a level premium for everyone, healthy people have to be charged more so that sick people can be charged less. And because most people are healthy, most people see their premiums rise.

Consider the impact on policies sold by Mutual of Omaha, one of the largest sellers of individual health insurance policies in the state:

- Before community rating was instituted in New York, a 25-year-old male on Long Island paid $81.64 a month for health insurance, and a 55-year-old paid $179.60.
- After community rating, both paid $135.95, a 67 percent increase for the 25-year-old and a 25 percent decrease for the 55-year-old.
- Because young, healthy people began canceling policies, by 1994 both paid $183.79 — more than the 55-year-old was paying *before* community rating was implemented — and by 1997 that community-rated premium had risen to $217.59 a month.

As a result of the departure of thousands, the uninsured population in New York City grew from 20.9 percent in 1990 to 24.8 percent in 1995, according to one report, while the national rate grew from 16.6 percent to 17.4 percent over that same period.

Guaranteed Issue in New Jersey. The most astonishing case is that of New Jersey, which publishes its health insurance rates. As a result of New Jersey's guaranteed issue and community rating law:

- A standard family health insurance policy ($500 deductible, 20 percent copayment) averages $1,559 per month, or $18,708 a year, as of June 1997 — with the lowest rate being $830 and the highest $2,930 per month, or $35,160 a year.
- In April 1995 that same plan cost on average about $750 per month — less than half the current amount.
- Even the state's most restrictive HMOs cost more than $700 a month for family coverage — nearly twice the national average.

By contrast, neighboring Pennsylvania, which has not implemented guaranteed issue and community rating, has relatively low premiums — about $300 per month for a 37-year-old head of family in Reading, Pa. — for a policy similar to that in New Jersey.

As a result of New Jersey's intervention in the health insurance marketplace, coverage in the individual health insurance market has declined by about 15 percent since the end of 1994.

Guaranteed Issue in New Hampshire. New Hampshire passed guaranteed issue in 1995. Insurers began to lose money and either raised premiums to unaffordable levels or pulled out of the market. According to a statement by the state's insurance commissioner, "individual health insurance is not readily available in New Hampshire."

To halt the deterioration of the individual health insurance market, health insurers in the group market were assessed $2.16 per covered person. Of course, that action will raise the cost of group insurance and may lead some employers to cancel their policies immediately or as the assessment grows.

Government Regulations Are the Problem. In 1998 the Washington-based Galen Institute released a study that verified what health policy people had been predicting all along: the government is the problem.

The study analyzed the impact of health insurance reform laws in 16 of the most aggressive states meant to increase access and decrease the number of uninsured. According to the study: "In 1996, all 16 states experienced an average annual growth in their uninsured population eight times that of the other 34. In 1996, the one-year average growth rate in the uninsured population in the 16 regulatory states was 8.14 percent; in the other 34 states, however, it had fallen to only 1.02 percent. In 1990, before the blizzard of health care reform legislation, the two groups of states had been nearly equal at 4.6 percent and 3.9 percent, respectively."

How to Decrease the Number of Uninsured

If Congress really wants to address the problem of the uninsured, it should:

- Change the tax system, such as shifting to a fixed-sum tax credit that would be available to every American, so that it encourages everyone to obtain a basic health insurance policy.
- Avoid imposing mandates and other regulations such as guaranteed issue that make health insurance and managed care more expensive.
- Expand the availability of Medical Savings Accounts.

Each of these reforms would reduce the cost of health insurance and health care and encourage more people to become insured.

Conclusion

There is no mystery as to why the number of uninsured as well as health care costs are growing: Congress and several state legislatures keep trying to make health insurance more accessible and affordable. If they would quit trying to help, the growth in health insurance premiums would decline — as they did in the early '90s when national health care reform failed — and so would the number of uninsured.

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